

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12309 CERTIFICATE OF DEATH										Reg. Dist. No. 12306				
1. PLACE OF DEATH a. COUNTY Carroll					MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville					c. LENGTH OF STAY IN 1b 52 yrs. 4 mos. 28 days. Baltimore City					b. COUNTY				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City					3 VD 1-4				
3. NAME OF DECEASED (Type or print) Frederick					First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
					William		Abbis	11	5	1958				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 1874		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? unknown								
13. FATHER'S NAME unknown					14. MOTHER'S MAIDEN NAME Christina -									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. unknown			17. INFORMANT Hospital Records			Address Springfield State Hosp. Sykesville, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left myocardial infarction DUE TO Cronary ARTERIOSCLEROSIS										INTERVAL BETWEEN ONSET AND DEATH months years				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type.										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____											
20c. TIME OF INJURY Month Day Year Hour a.m. _____ p.m. _____ 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____		(County)		(State)			
21. I certify that I attended the deceased from August , 19 55 , to Nov. 5 , 19 58 , that I last saw the deceased alive on November 4 , 19 58 , and that death occurred at 8:25 AM , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Walter Knopp, M.D.			DATE SIGNED	
ACTUAL SIGNATURE <i>Walter Knopp, M.D.</i>										M.D. Springfield State Hospital				
PHYSICIAN'S NAME (Type) Walter Knopp, M.D.										Sykesville, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-7-58		22c. NAME OF CEMETERY OR CREMATORIUM WESTERN		22d. LOCATION (City, town, or county) Baltimore Md.		(State)						
23. FUNERAL DIRECTOR'S SIGNATURE <i>Geo. L. Schaefer</i>		ADDRESS 2101 Frederick Ave		24a. REC'D BY REGISTRAR NOV 7 '58		24b. REGISTRAR'S SIGNATURE <i>John J. Tracy</i>								

11/150 20 STAD 9/82

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12310

CERTIFICATE OF DEATH

Reg. Dist. No. 12307

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY City 311				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 4 months 29 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4				
3. NAME OF DECEASED (Type or print)	First William	Middle George	Last Albright			
4. DATE OF DEATH	Month 11-	Day 22	Year -1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-81	9. AGE (In years 77 In months birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, Belt Machinist		10b. KIND OF BUSINESS OR INDUSTRY Continental Can		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Cyrus Albright		14. MOTHER'S MAIDEN NAME Elizabeth Philathea Fishpaw		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-09-8394		17. INFORMANT Hospital records.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S., associated with semile brain disease, with psychotic reaction						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from alive on 11-22-1958,		11-22-, 1958, to 11-22-, 1958, that I last saw the deceased alive on 11-22-, 1958, and that death occurred at 11:00P.M. from the causes and on the date stated above.				
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11-23-58				
PHYSICIAN'S NAME (Type) Agustin del Campo M.D.		Sykesville, Maryland.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 26, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home		ADDRESS 3631 Falls Road		24a. REC'D BY REGISTRAR DATE NOV 25 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH	DEATH DATE	TIME	PLACE	NAME OF DOCTOR	ADDRESS
John Doe	55	M	Heart Disease	1999-01-01	10:00 AM	Hospital	Dr. John Smith	123 Main Street
Additional Information								
This certificate is issued by the State of Health - Vital Statistics.								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
12311 CERTIFICATE OF DEATH									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <i>Carroll</i>					a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mount Airy</i>					c. LENGTH OF STAY IN 1b <i>9 days</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>North Main</i>					e. STREET ADDRESS <i>North Main</i>				
3. NAME OF DECEASED (Type or print) <i>Sarah Elizabeth Allsop</i>					4. DATE OF DEATH <i>November 15 1958</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 29, 1876</i>		9. AGE (In years lost birthday) yrs. <i>82</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>				
11. BIRTHPLACE (State or foreign country) <i>Missouri</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				
13. FATHER'S NAME <i>William Bloomer</i>					14. MOTHER'S MAIDEN NAME <i>Eliza Stean</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. <i>—</i>				
17. INFORMANT <i>Sara Allsop (Daughter) - 1</i>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i>					1 year				
290.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pernicious Anemia					30 years				
DUE TO (c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Nov. 12, 1958</u> , to <u>Nov. 15, 1958</u> , that I last saw the deceased alive on <u>Nov. 12, 1958</u> , and that death occurred at <u>12:05</u> A.M., from the causes and on the date stated above.					ADDRESS (Street, city or town, state)				
ACTUAL SIGNATURE <i>W.B. Culwell</i>					DATE SIGNED <i>Nov. 15, 1958</i>				
PHYSICIAN'S NAME (Type) <i>W.B. Culwell</i>					M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 17, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Oakland Mem. Cemetery</i>		22d. LOCATION (City, town, or county) <i>Indiana, Pennsylvania</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Olin J. Molesworth</i>					ADDRESS <i>Damascus, Md.</i>				
24a. REC'D BY REGISTRAR <i>Arthur S. Thorne</i>					24b. REGISTRAR'S SIGNATURE				
DATE <i>NOV 18 '58</i>									

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12312 CERTIFICATE OF DEATH										Reg. Dist. No. 12309	
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenmount		c. LENGTH OF STAY IN lb 10 yrs			c. CITY OF OWN (If outside corporate limits, write RURAL and give nearest town) Greenmount		d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ✓											
3. NAME OF DECEASED (Type or print) JULIA First - F - ARMACOST Middle Lost		4. DATE OF DEATH Nov 28 1958									
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 1-1874			9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Hulk			11. BIRTHPLACE (State or foreign country) Md			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME David Rineau			14. MOTHER'S MAIDEN NAME Mary Ann Schultz								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 17. INFORMANT No Mrs. Maurice Smith-Greenmount Md								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 24 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Viral respiratory infection (1st two weeks November)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from November 1st 1958, to November 28 1958, that I last saw the deceased alive on November 28, 1958, and that death occurred at 4:40 PM, from the causes and on the date stated above. ACTUAL SIGNATURE M.C. Porterfield M.D.									ADDRESS (Street, city or town, state) Hampstead, Md. DATE SIGNED 11/29/58		
PHYSICIAN'S NAME (Type) M.C. Porterfield, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 1/58		22c. NAME OF CEMETERY OR CREMATORIUM Greenmount		22d. LOCATION (City, town, or county) Carroll Co Md		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Edele S. Tipton		ADDRESS Hampstead Md		24a. REC'D BY REGISTRAR DATE DEC 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House					
VS A1S (4) 1SM 9/55											

STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES

CERTIFICATE TO DEATH

Address _____
Telephone number _____
Date _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 12310					
12313 CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore County 03										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 1mth. 5days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Granite			d. STREET ADDRESS Summit Ave.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.										e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Forrest	Middle Eugene	Last Ayer	4. DATE OF DEATH Month 11 Day 22 Year 1958										
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-15-83		9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter					10b. KIND OF BUSINESS OR INDUSTRY <i>Bldg Const.</i>			11. BIRTHPLACE (State or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Samuel B. Ayer					14. MOTHER'S MAIDEN NAME Anza Thorn										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital records.				Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH years					
(b) Generalized arteriosclerosis DUE TO (c)										years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. associated with cerebral arteriosclerosis, without qualifying phrase-Bronchopneumonia. 491X										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.							20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-17- 1958 to 11-22- 1958 , that I last saw the deceased alive on 11- 22- 1958 , and that death occurred at 3:55 P.M. , from the causes and on the date stated above.										ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <i>Agustin del Campo</i> PHYSICIAN'S NAME (Type) Agustin del Campo M.D.										DATE SIGNED 11-22-58					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 11-26-58		22c. NAME OF CEMETERY OR CREMATORIUM WESTLEY Chapel			22d. LOCATION (City, town, or county) Knottsville W. Virginia		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>GEO. L. Schwab Funeral Home</i> <i>Barbara M. Schwab 2101 Frederick Ave.</i>			ADDRESS		24a. REC'D BY REGISTRAR NOV 24 1958			24b. REGISTRAR'S SIGNATURE <i>Orton J. Knott</i>							

CHARGES OF DEATH

NAME	AGE	SEX	DEATH DATE	CAUSE OF DEATH	DEATH NUMBER
John Doe	55	M	1985-07-15	Cardiac Arrest	1234567890
Jane Smith	42	F	1985-08-20	Cancer	1234567891
Bob Johnson	68	M	1985-09-10	Stroke	1234567892
Susan Williams	30	F	1985-10-05	Car Accident	1234567893
David Lee	72	M	1985-11-25	Alzheimer's	1234567894
Emily Green	25	F	1985-12-12	Pneumonia	1234567895
Mark Wilson	48	M	1986-01-08	Heart Failure	1234567896
Karen Clark	35	F	1986-02-15	Stroke	1234567897
Tommy Brown	62	M	1986-03-22	Diabetes	1234567898
Linda Taylor	45	F	1986-04-18	Breast Cancer	1234567899
Steve Parker	50	M	1986-05-05	Stroke	1234567890
Christina White	32	F	1986-06-12	Heart Attack	1234567891
Mike Jones	65	M	1986-07-18	Alzheimer's	1234567892
Sarah Davis	28	F	1986-08-25	Stroke	1234567893
Jeffrey Lewis	40	M	1986-09-11	Heart Disease	1234567894
Michelle Young	38	F	1986-10-18	Stroke	1234567895
Kevin Miller	58	M	1986-11-25	Alzheimer's	1234567896
April Foster	22	F	1986-12-12	Stroke	1234567897
Brian Parker	60	M	1987-01-08	Heart Failure	1234567898
Rebecca Clark	37	F	1987-02-15	Stroke	1234567899
Gregory Brown	55	M	1987-03-22	Alzheimer's	1234567890
Leah Taylor	33	F	1987-04-18	Heart Attack	1234567891
Matthew Parker	42	M	1987-05-05	Stroke	1234567892
Christine Young	30	F	1987-06-12	Heart Disease	1234567893
Jeffrey Lewis	45	M	1987-07-18	Alzheimer's	1234567894
Michelle Foster	26	F	1987-08-25	Stroke	1234567895
Kevin Clark	53	M	1987-09-11	Heart Failure	1234567896
April Foster	31	F	1987-10-18	Stroke	1234567897
Brian Parker	58	M	1987-11-25	Alzheimer's	1234567898
Leah Young	28	F	1987-12-12	Heart Attack	1234567899
Matthew Clark	43	M	1988-01-08	Stroke	1234567890
Christine Lewis	34	F	1988-02-15	Heart Disease	1234567891
Jeffrey Foster	48	M	1988-03-22	Alzheimer's	1234567892
Michelle Parker	30	F	1988-04-18	Stroke	1234567893
Kevin Clark	55	M	1988-05-05	Heart Failure	1234567894
April Lewis	27	F	1988-06-12	Stroke	1234567895
Brian Foster	59	M	1988-07-18	Alzheimer's	1234567896
Leah Parker	32	F	1988-08-25	Heart Attack	1234567897
Matthew Clark	44	M	1988-09-11	Stroke	1234567898
Christine Lewis	35	F	1988-10-18	Heart Disease	1234567899
Jeffrey Foster	49	M	1988-11-25	Alzheimer's	1234567890
Michelle Clark	31	F	1988-12-12	Stroke	1234567891
Kevin Lewis	56	M	1989-01-08	Heart Failure	1234567892
April Parker	29	F	1989-02-15	Stroke	1234567893
Brian Foster	60	M	1989-03-22	Alzheimer's	1234567894
Leah Clark	33	F	1989-04-18	Heart Attack	1234567895
Matthew Lewis	45	M	1989-05-05	Stroke	1234567896
Christine Foster	30	F	1989-06-12	Heart Disease	1234567897
Jeffrey Clark	57	M	1989-07-18	Alzheimer's	1234567898
Michelle Lewis	28	F	1989-08-25	Stroke	1234567899
Kevin Foster	54	M	1989-09-11	Heart Failure	1234567890
April Clark	31	F	1989-10-18	Stroke	1234567891
Brian Lewis	59	M	1989-11-25	Alzheimer's	1234567892
Leah Foster	34	F	1989-12-12	Heart Attack	1234567893
Matthew Clark	46	M	1990-01-08	Stroke	1234567894
Christine Lewis	36	F	1990-02-15	Heart Disease	1234567895
Jeffrey Foster	50	M	1990-03-22	Alzheimer's	1234567896
Michelle Clark	32	F	1990-04-18	Stroke	1234567897
Kevin Lewis	58	M	1990-05-05	Heart Failure	1234567898
April Foster	30	F	1990-06-12	Stroke	1234567899
Brian Clark	61	M	1990-07-18	Alzheimer's	1234567890
Leah Foster	35	F	1990-08-25	Heart Attack	1234567891
Matthew Lewis	47	M	1990-09-11	Stroke	1234567892
Christine Clark	33	F	1990-10-18	Heart Disease	1234567893
Jeffrey Lewis	55	M	1990-11-25	Alzheimer's	1234567894
Michelle Foster	31	F	1990-12-12	Stroke	1234567895
Kevin Foster	59	M	1991-01-08	Heart Failure	1234567896
April Lewis	34	F	1991-02-15	Stroke	1234567897
Brian Clark	63	M	1991-03-22	Alzheimer's	1234567898
Leah Lewis	37	F	1991-04-18	Heart Attack	1234567899
Matthew Foster	49	M	1991-05-05	Stroke	1234567890
Christine Clark	35	F	1991-06-12	Heart Disease	1234567891
Jeffrey Lewis	57	M	1991-07-18	Alzheimer's	1234567892
Michelle Foster	33	F	1991-08-25	Stroke	1234567893
Kevin Lewis	55	M	1991-09-11	Heart Failure	1234567894
April Clark	36	F	1991-10-18	Stroke	1234567895
Brian Lewis	62	M	1991-11-25	Alzheimer's	1234567896
Leah Foster	38	F	1991-12-12	Heart Attack	1234567897
Matthew Clark	50	M	1992-01-08	Stroke	1234567898
Christine Lewis	36	F	1992-02-15	Heart Disease	1234567899
Jeffrey Clark	58	M	1992-03-22	Alzheimer's	1234567890
Michelle Lewis	34	F	1992-04-18	Stroke	1234567891
Kevin Lewis	56	M	1992-05-05	Heart Failure	1234567892
April Lewis	32	F	1992-06-12	Stroke	1234567893
Brian Foster	64	M	1992-07-18	Alzheimer's	1234567894
Leah Foster	39	F	1992-08-25	Heart Attack	1234567895
Matthew Foster	51	M	1992-09-11	Stroke	1234567896
Christine Lewis	37	F	1992-10-18	Heart Disease	1234567897
Jeffrey Lewis	59	M	1992-11-25	Alzheimer's	1234567898
Michelle Lewis	35	F	1992-12-12	Stroke	1234567899
Kevin Lewis	57	M	1993-01-08	Heart Failure	1234567890
April Clark	38	F	1993-02-15	Stroke	1234567891
Brian Clark	65	M	1993-03-22	Alzheimer's	1234567892
Leah Clark	40	F	1993-04-18	Heart Attack	1234567893
Matthew Lewis	48	M	1993-05-05	Stroke	1234567894
Christine Lewis	38	F	1993-06-12	Heart Disease	1234567895
Jeffrey Lewis	56	M	1993-07-18	Alzheimer's	1234567896
Michelle Lewis	36	F	1993-08-25	Stroke	1234567897
Kevin Lewis	58	M	1993-09-11	Heart Failure	1234567898
April Lewis	34	F	1993-10-18	Stroke	1234567899
Brian Lewis	62	M	1993-11-25	Alzheimer's	1234567890
Leah Lewis	41	F	1993-12-12	Heart Attack	1234567891
Matthew Clark	49	M	1994-01-08	Stroke	1234567892
Christine Lewis	39	F	1994-02-15	Heart Disease	1234567893
Jeffrey Lewis	57	M	1994-03-22	Alzheimer's	1234567894
Michelle Lewis	37	F	1994-04-18	Stroke	1234567895
Kevin Lewis	59	M	1994-05-05	Heart Failure	1234567896
April Lewis	35	F	1994-06-12	Stroke	1234567897
Brian Lewis	63	M	1994-07-18	Alzheimer's	1234567898
Leah Lewis	42	F	1994-08-25	Heart Attack	1234567899
Matthew Clark	50	M	1994-09-11	Stroke	1234567890
Christine Lewis	38	F	1994-10-18	Heart Disease	1234567891
Jeffrey Lewis	56	M	1994-11-25	Alzheimer's	1234567892
Michelle Lewis	36	F	1994-12-12	Stroke	1234567893
Kevin Lewis	58	M	1995-01-08	Heart Failure	1234567894
April Lewis	34	F	1995-02-15	Stroke	1234567895
Brian Lewis	61	M	1995-03-22	Alzheimer's	1234567896
Leah Lewis	39	F	1995-04-18	Heart Attack	1234567897
Matthew Clark	47	M	1995-05-05	Stroke	1234567898
Christine Lewis	37	F	1995-06-12	Heart Disease	1234567899
Jeffrey Lewis	55	M	1995-07-18	Alzheimer's	1234567890
Michelle Lewis	35	F	1995-08-25	Stroke	1234567891
Kevin Lewis	57	M	1995-09-11	Heart Failure	1234567892
April Lewis	33	F	1995-10-18	Stroke	1234567893
Brian Lewis	60	M	1995-11-25	Alzheimer's	1234567894
Leah Lewis	38	F	1995-12-12	Heart Attack	1234567895
Matthew Clark	48	M	1996-01-08	Stroke	1234567896
Christine Lewis	36	F	1996-02-15	Heart Disease	1234567897
Jeffrey Lewis	54	M	1996-03-22	Alzheimer's	1234567898
Michelle Lewis	34	F	1996-04-18	Stroke	1234567899
Kevin Lewis	56	M	1996-05-05	Heart Failure	1234567890
April Lewis	32	F	1996-06-12	Stroke	1234567891
Brian Lewis	59	M	1996-07-18	Alzheimer's	1234567892
Leah Lewis	37	F	1996-08-25	Heart Attack	1234567893
Matthew Clark	45	M	1996-09-11	Stroke	1234567894
Christine Lewis	35	F	1996-10-18	Heart Disease	1234567895
Jeffrey Lewis	53	M	1996-11-25	Alzheimer's	1234567896
Michelle Lewis	33	F	1996-12-12	Stroke	1234567897
Kevin Lewis	55	M	1997-01-08	Heart Failure	1234567898
April Lewis	31	F	1997-02-15	Stroke	1234567899
Brian Lewis	58	M	1997-03-22	Alzheimer's	1234567890
Leah Lewis	36	F	1997-04-18	Heart Attack	1234567891
Matthew Clark	43	M	1997-05-05	Stroke	1234567892
Christine Lewis	34	F	1997-06-12	Heart Disease	1234567893
Jeffrey Lewis	51	M	1997-07-18	Alzheimer's	1234567894
Michelle Lewis	32	F	1997-08-25	Stroke	1234567895
Kevin Lewis	54	M	1997-09-11	Heart Failure	1234567896
April Lewis	30	F	1997-10-18	Stroke	1234567897
Brian Lewis	57	M	1997-11-25	Alzheimer's	1234567898
Leah Lewis	35	F	1997-12-12	Heart Attack	1234567899
Matthew Clark	41	M	1998-01-08	Stroke	1234567890
Christine Lewis	33	F	1998-02-15	Heart Disease	1234567891
Jeffrey Lewis	50	M	1998-03-22	Alzheimer's	1234567892
Michelle Lewis	31	F	1998-04-18	Stroke	1234567893
Kevin Lewis	53	M	1998-05-05	Heart Failure	1234567894
April Lewis	29	F	1998-06-12	Stroke	1234567895
Brian Lewis	56	M	1998-07-18	Alzheimer's	1234567896
Leah Lewis	32	F	1998-08-25	Heart Attack	1234567897
Matthew Clark	38	M	1998-09-11	Stroke	1234567898
Christine Lewis	30	F	1998-10-18	Heart Disease	1234567899
Jeffrey Lewis	48	M	1998-11-25	Alzheimer's	1234567890
Michelle Lewis	28	F	1998-12-12	Stroke	1234567891
Kevin Lewis	51	M	1999-01-08	Heart Failure	1234567892
April Lewis	26	F	1999-02-15	Stroke	1234567893
Brian Lewis	54	M	1999-03-22	Alzheimer's	1234567894
Leah Lewis	29	F	1999-04-18	Heart Attack	1234567895
Matthew Clark	42	M	1999-05-05	Stroke	1234567896
Christine Lewis	28	F	1999-06-12	Heart Disease	1234567897
Jeffrey Lewis	46	M	1999-07-18	Alzheimer's	1234567898
Michelle Lewis	26	F	1999-08-25	Stroke	1234567899
Kevin Lewis	49	M	1999-09-11	Heart Failure	1234567890
April Lewis	24	F	1999-10-18	Stroke	1234567891
Brian Lewis	52	M	1999-11-25	Alzheimer's	1234567892
Leah Lewis	27	F	1999-12-12	Heart Attack	1234567893
Matthew Clark	36	M	2000-01-08	Stroke	1234567894
Christine Lewis	26	F	2000-02-15	Heart Disease	1234567895
Jeffrey Lewis	44	M	2000-03-22	Alzheimer's	1234567896
Michelle Lewis	24	F	2000-04-18	Stroke	1234567897
Kevin Lewis	47	M	2000-05-05	Heart Failure	1234567898
April Lewis	22	F	2000-06-12	Stroke	1234567899
Brian Lewis	49	M	2000-07-18	Alzheimer's	1234567890
Leah Lewis	25	F	2000-08-25	Heart Attack	1234567891
Matthew Clark	34	M	2000-09-11	Stroke	1234567892
Christine Lewis	24	F	2000-10-18	Heart Disease	1234567893
Jeffrey Lewis	42	M	2000-11-25	Alzheimer's	1234567894
Michelle Lewis	22	F	2000-12-12	Stroke	1234567895
Kevin Lewis	45	M	2001-01-08	Heart Failure	1234567896
April Lewis	20	F	2001-02-15	Stroke	1234567897
Brian Lewis	47	M	2001-03-22	Alzheimer's	1234567898
Leah Lewis	23	F	2001-04-18	Heart Attack	1234567899
Matthew Clark	32	M	2001-05-05	Stroke	1234567890
Christine Lewis	22	F	2001-06-12	Heart Disease	1234567891
Jeffrey Lewis	40	M	2001-07-18	Alzheimer's	1234567892
Michelle Lewis	20	F	2001-08-25	Stroke	1234567893
Kevin Lewis	43	M	2001-09-11	Heart Failure	1234567894
April Lewis	18	F	2001-10-18	Stroke	1234567895
Brian Lewis	45	M	2001-11-25	Alzheimer's	1234567896
Leah Lewis	21	F	2001-12-12	Heart Attack	1234567897
Matthew Clark	30	M	2002-01-08	Stroke	1234567898
Christine Lewis	20	F	2002-02-15	Heart Disease	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 12311		
12311 CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 2mos. 3 days		b. COUNTY Frederick			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital					d. STREET ADDRESS 313 S. Market St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Also known as Franklin E. Bartholow) lost (Type or print) Frank Edwin Bartholow					4. DATE OF DEATH Month November Day 5 Year 1958							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 8, 1885		9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Marshall B. Bartholow					14. MOTHER'S MAIDEN NAME Alice Stoner							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)			16. SOCIAL SECURITY NO			17. INFORMANT			Address			
No			-			Springfield Hospital Records						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic heart disease										INTERVAL BETWEEN ONSET AND DEATH Years		
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b). DUE TO (c).												
C. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction plus C.B.S. with convulsive disorder.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from September 2, 1958, to November 5, 1958, that I last saw the deceased alive on November 5, 1958, and that death occurred at 10:30 AM from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Edmund Lusthaus M.D. Springfield Hospital Sykesville, Maryland DATE SIGNED 11/6/58		
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)		Edmund Lusthaus, M.D.		Sykesville, Maryland						
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 10, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR NOV 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus						

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12315

CERTIFICATE OF DEATH

12312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR		b. COUNTY CARROLL	
c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First EDWARD	Middle C. BIXLER	Last Month Day Year Nov. 5 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 1-1877
9. AGE (In years last birthday) yrs 81	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER-TEACHER	11. KIND OF BUSINESS OR INDUSTRY COLLEGE	12. BIRTHPLACE (State or foreign country) MARYLAND
13. CITIZEN OF WHAT COUNTRY? U.S.	14. MOTHER'S MAIDEN NAME SARAH MYERS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT MRS KATH BARNETT, NEW WINDSOR MD	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 1 1958 to Nov 5 1958 , that I last saw the deceased alive on Nov 3 1958 , and that death occurred at 9 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Reeseville, M.D. DATE SIGNED DR. REESE WILKENS	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/8/58	
22c. NAME OF CEMETERY OR CREMATORIAL PIPE CREEK		22d. LOCATION (City, town, or county) CARROLL COUNTY MD	
23. FUNERAL DIRECTOR'S SIGNATURE DD Hartfusions NEW WINDSOR MD		24a. REC'D BY REGISTRAR DATE NOV 1 1958	
ADDRESS 1		24b. REGISTRAR'S SIGNATURE Calvin S. Knapp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Loge may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12316 CERTIFICATE OF DEATH										Reg. Dist. No. 12313			
1. PLACE OF DEATH a. COUNTY Carroll					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleburg		c. LENGTH OF STAY IN b Rural Lifetime			d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleburg		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			b. COUNTY Carroll			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS								
3. NAME OF DECEASED (Type or print)		First Jesse		Middle Albertus		Last Bostian		4. DATE OF DEATH November 28 1958					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1879	9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. FATHER'S NAME Jacob Bostian	14. MOTHER'S MAIDEN NAME Sarah Eytler	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO 216-10-9805	17. INFORMANT Mrs. Jesse A. Bostian, Middleburg, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]											
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)					
21. I certify that I attended the deceased from Nov 28, 1958 to Nov 28, 1958 , that I last saw the deceased alive on Nov 28, 1958 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) 1100 Main Bridge Rd. 11-19-58	DATE SIGNED		
ACTUAL SIGNATURE T. H. Legg MD													
PHYSICIAN'S NAME (Type)		22. BURIAL, CREMATION, REMOVAL (Specify) Burial								22c. NAME OF CEMETERY OR CREMATORIUM Haugh's Cemetery	22d. LOCATION (City, town, or county) Ladiesburg, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss		ADDRESS Taneytown, Maryland								24a. REC'D BY REGISTRAR DEC 3 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

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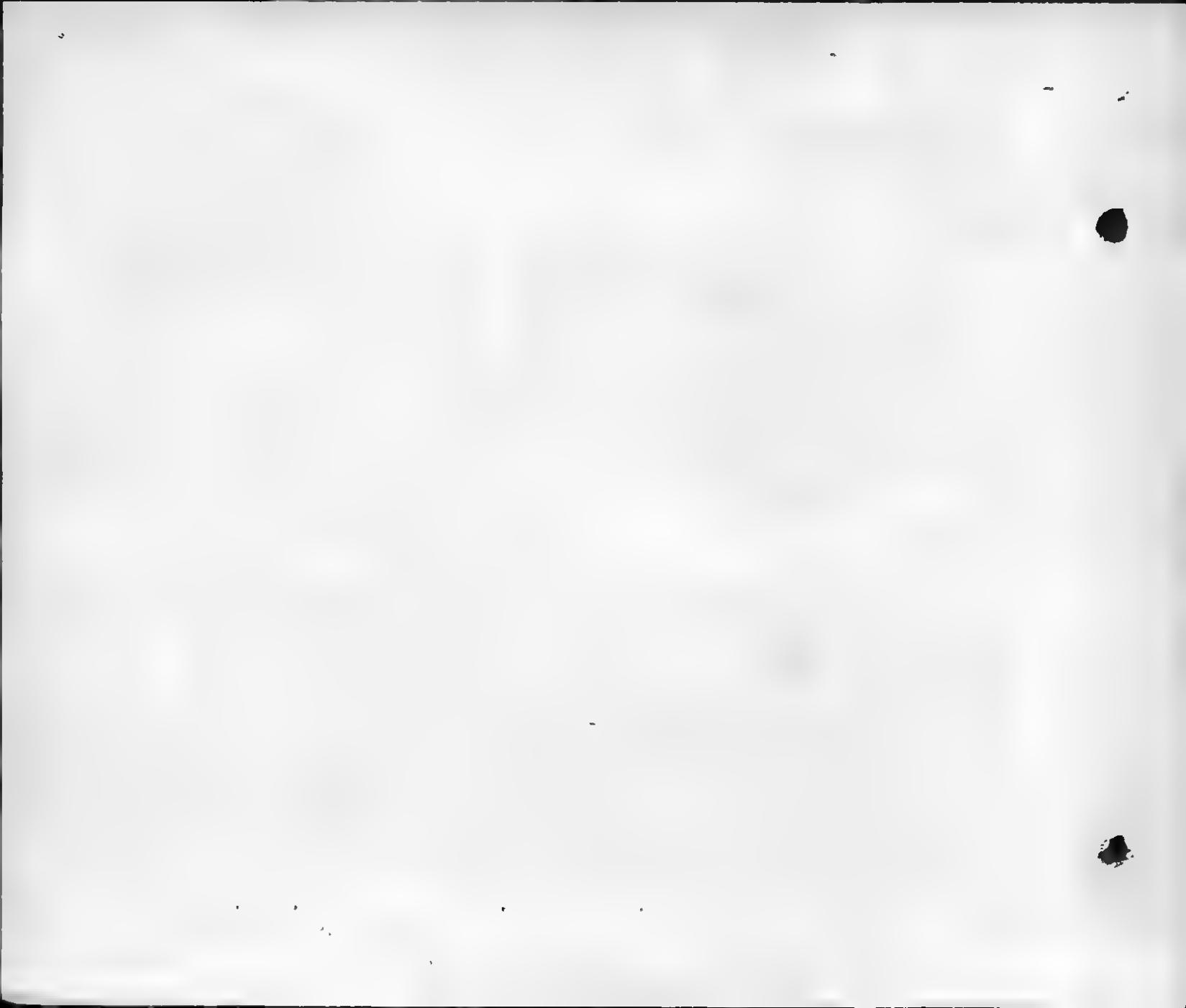
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12317 CERTIFICATE OF DEATH

12314

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wilmington</i>	c. LENGTH OF STAY IN 1b <i>3 1/2 yrs.</i>	b. COUNTY <i>Carroll</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wilmington</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hause - 7</i>	e. STREET ADDRESS <i>187</i>	f. DATE OF DEATH <i>Nov 13 1958</i>	g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
h. STREET ADDRESS <i>Box 160 A</i>	i. Month <i>Nov</i>	j. Day <i>13</i>	k. Year <i>1958</i>				
l. NAME OF DECEASED (Type or print) <i>ELSIE</i>	m. First <i>VIRGINIA</i>	n. Middle <i>BROOKS</i>	o. DATE OF BIRTH <i>Jan 13 1884</i>				
p. SEX <i>F</i>	q. COLOR OR RACE <i>W</i>	r. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	s. AGE (In years last birthday) <i>74 yrs.</i>				
t. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	u. KIND OF BUSINESS OR INDUSTRY <i>Now home</i>	v. BIRTHPLACE (State or foreign country) <i>Maryland - USA</i>	w. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
x. FATHER'S NAME <i>William - b. Purcell</i>	y. MOTHER'S MAIDEN NAME <i>Laura m Haines</i>	z. Address <i>Mauree C Brooks 187 Westminster Md</i>					
aa. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	bb. SOCIAL SECURITY NO. (If yes, give war or dates of service)	cc. INFORMANT <i>Mauree C Brooks</i>	dd. INTERVAL BETWEEN ONSET AND DEATH <i>1 yr - years.</i>				
ee. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Infective Ca of lung</i> DUE TO (c) <i>Ca of Breast</i>							
ff. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
gg. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		hh. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
ii. TIME OF INJURY Hour a. m. p. m.	jj. Month, Doy, Year 19	kk. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	ll. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	mm. (City or town) <i>105 E MAIN St</i>	nn. (County)	oo. (State) <i>Wilmington</i>	
pp. I certify that I attended the deceased from <i>Nov 12</i> , 1958, to <i>Nov 13</i> , 1958, that I last saw the deceased alive on <i>Nov 13</i> , 1958, and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.							
qq. ACTUAL <i>James T. Marsh</i>				rr. ADDRESS (Street, city or town, state) <i>105 E MAIN St - 11/3/58</i>	ss. DATE SIGNED <i>11/3/58</i>		
tt. PHYSICIAN'S NAME (Type) <i>JAMES T. MARSH</i>		uu. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		vv. DATE THEREOF <i>11/17/58</i>	xx. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cem.</i>	yy. LOCATION (City, town, or county) <i>Balto., Md.</i>	zz. (State) <i>Wilmington</i>
zz. FUNERAL DIRECTOR'S SIGNATURE <i>Jim J. Lickner & Sons - Baetz</i>		aa. ADDRESS <i>11/17/58</i>		bb. REC'D BY REGISTRAR <i>NOV 17 '58</i>	cc. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12304

CERTIFICATE OF DEATH

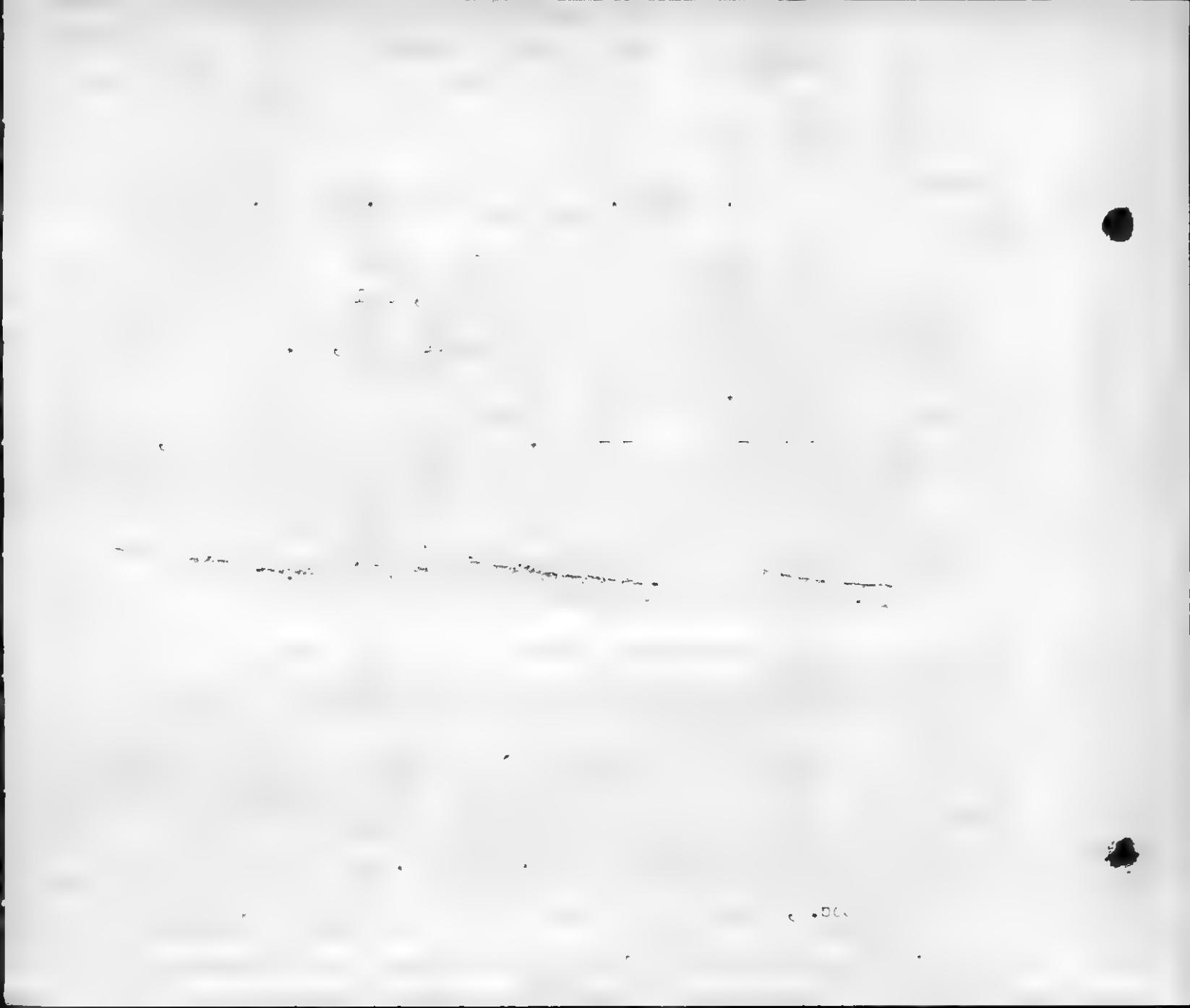
12315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 E. Green St.				d. STREET ADDRESS 119 E. Green St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Minerva	Middle Agnes	Last Burner	4. DATE OF DEATH Month November Day 28 Year 1958		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1871	9. AGE (In years from birthday) 87 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Merryman				14. MOTHER'S MAIDEN NAME Irena Purkey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Eunice Buckingham Westminster, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetus Mellitus</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Myocarditis & Bronchitis yrs</i> DUE TO (c) <i>Arterio Sclerosis (Genl)</i>				INTERVAL BETWEEN ONSET AND DEATH 10-15 yrs			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August 19, 1957, to August 28, 1958</i> , that I last saw the deceased alive on <i>Aug 28, 1958</i> , and that death occurred at <i>11:58 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W. Glenn Speicher</i>		ADDRESS (Street, city or town, state) <i>135 E. Main St. Westminster, Maryland</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 1, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Westminster Cemetery		22d. LOCATION (City, town, or county) (State) Westminster, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Maryland		24a. REC'D BY REGISTRAR DATE DEC 2 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12318

CERTIFICATE OF DEATH

12316

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore City 311	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 16 months, 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6	
3. NAME OF DECEASED (Type or print) First Bessie Middle Margaret Last Caldwell		d. STREET ADDRESS 5417 Belle Vista Avenue	
4. DATE OF DEATH Month 11 Day 21 Year 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female White		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH March 30, 1896		9. AGE (In years less birthday) yrs. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Housewife) Waitress		10b. KIND OF BUSINESS OR INDUSTRY F.W. Woolworth	
11. BIRTHPLACE (State or foreign country) Maryland (Baltimore)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Griggs		14. MOTHER'S MAIDEN NAME Margaret Cooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 216-16-4563	
17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416 X DUE TO Bilateral Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Chronic Rheumatic Heart Disease Years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mental Deficiency		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-28-1958 to 11-21-1958, that I last saw the deceased alive on 11-21-1958, and that death occurred at 9:00 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Agustín del Campo, M.D. Springfield State Hospital 11-22-58	
ACTUAL SIGNATURE Agustín del Campo, M.D.		PHYSICIAN'S NAME (Type) Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-25-58	
22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR NOV 25 '58	
		24b. PEGISTRAR'S SIGNATURE Cirugia & Hora	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1-2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957-07-28 07:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12319

CERTIFICATE OF DEATH

12317

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i> Maryland</i>		b. COUNTY <i> Carroll</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hospital (Rural)</i>		c. LENGTH OF STAY IN lb <i>1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead Rural</i>		d. STREET ADDRESS <i></i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOHN - WILLIAM - CAPE		First	Middle	Lost	4. DATE OF DEATH Nov 22 1958	Month	Day	Year
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept 14-1882	8. AGE (In years lost birthday) 76 yrs.	9. IF UNDER 1 YEAR Months 0 Days 0	10. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME <i>John Cape</i>		14. MOTHER'S MAIDEN NAME <i>Susan Wink</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (Yes or no; give name or dates of service)		16. SOCIAL SECURITY NO 212-32-1204		17. INFORMANT Addie Shiltke - Upper Md		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.1		DUE TO <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH 0 min				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <i>Antemortem</i>		5 yrs				
(c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Ex post mortem		5 yrs				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Manchester, Md		20f. (City or town) (County) Manchester (State) Md		
21. I certify that I attended the deceased from Nov , 1956, to Nov 22 , 1958, that I last saw the deceased alive on April , 1958, and that death occurred at 10P M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Manchester, Md		DATE SIGNED 11-24-58		
ACTUAL SIGNATURE <i>W H Ford</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>W H Ford M.D.</i>						<i>MANCHESTER, MD</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Nov 25/58		22b. DATE THEREOF Nov 25/58		22c. NAME OF CEMETERY OR CREMATORIUM Reformed Cemetery		22d. LOCATION (City, town, or county) Manchester, Carroll Co Md		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Tipton, Hampstead Md</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR NOV 25 1958		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knott</i>		

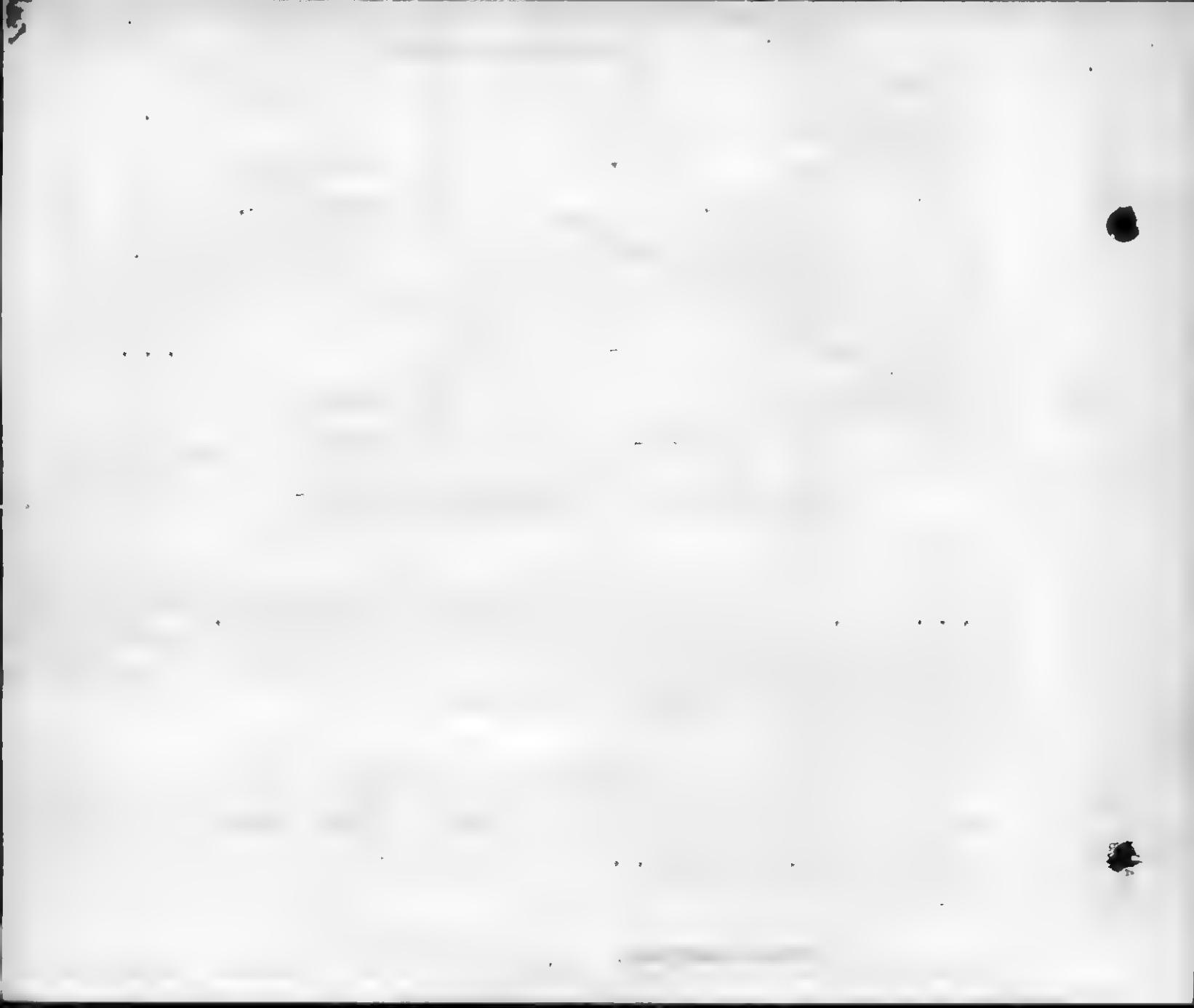


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12320 CERTIFICATE OF DEATH

12313

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o STATE Maryland b COUNTY Balto. City				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN HOSPITAL 5 mos. 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Dundalk				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 8155 Kavanaugh Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First James	Middle Austin	Last Casey	4. DATE OF DEATH Month November Day 14, Year 1958			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 20, 1899	9. AGE (in years last birthday) 59 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel erector		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Andrew Casey				14. MOTHER'S MAIDEN NAME Martha McIntire				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Springfield Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction due to arterio-sclerotic coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with alcohol intoxication without qualifying phrase.								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from May 29, 1958, to November 14, 1958, that I last saw the deceased alive on November 14, 1958, and that death occurred at 7:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <i>Irene L. Hitchman</i>		M.D.		Springfield State Hospital		11/15/58		
PHYSICIAN'S NAME (Type) Irene L. Hitchman, M.D.		Sykesville, Maryland						
22a. BURIAL, CREMATION, BURIAL (Specify) Burial		22b. DATE THEREOF Nov. 19, 58		22c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer		22d. LOCATION (City, town, or county) Belair Road (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DULIA 7922 Wise Ave. 22, Md.				ADDRESS		24a. REC'D BY REGISTRAR DNOV 18 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12321

CERTIFICATE OF DEATH

12319

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland		c. LENGTH OF STAY IN 1b Life		a. STATE Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 1500 E. Joppa Rd., Baltimore, Maryland		b. COUNTY Carroll	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) David Constantine		First	Middle	Last	4. DATE OF DEATH Nov. 30 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17 1900	9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Male Nurse		10b. KIND OF BUSINESS OR INDUSTRY Training		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME George E. Constantine		14. MOTHER'S MAIDEN NAME Elisabeth Shryfogle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 215-04-0944		17. INFORMANT Mrs. Helen Constantine - Joppa Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to Circumstances above, general illid		1955			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) one disease, Circumstances, external Due to (c) obstruction, multiple factors		to 30 Nov 1958			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on 30 Nov 1958, and that death occurred at 1229 M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Howard E. Haas, M.D. Sykesville, Md. 20 Nov 58			
ACTUAL SIGNATURE Howard E. Haas		DATE SIGNED			
PHYSICIAN'S NAME (Type) Howard E. Haas					
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral		22b. DATE THEREOF 12-3-58		22c. NAME OF CEMETERY OR CREMATORIAL Evergreen Memorial	
22d. LOCATION (City, town, or county) Baltimore, Carroll Co., Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Father & Son		ADDRESS 1500 E. Joppa Rd., Baltimore, Maryland		24a. REC'D BY REGISTRAR DEC 2 '58	
				24b. REGISTRAR'S SIGNATURE Charles E. Haas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

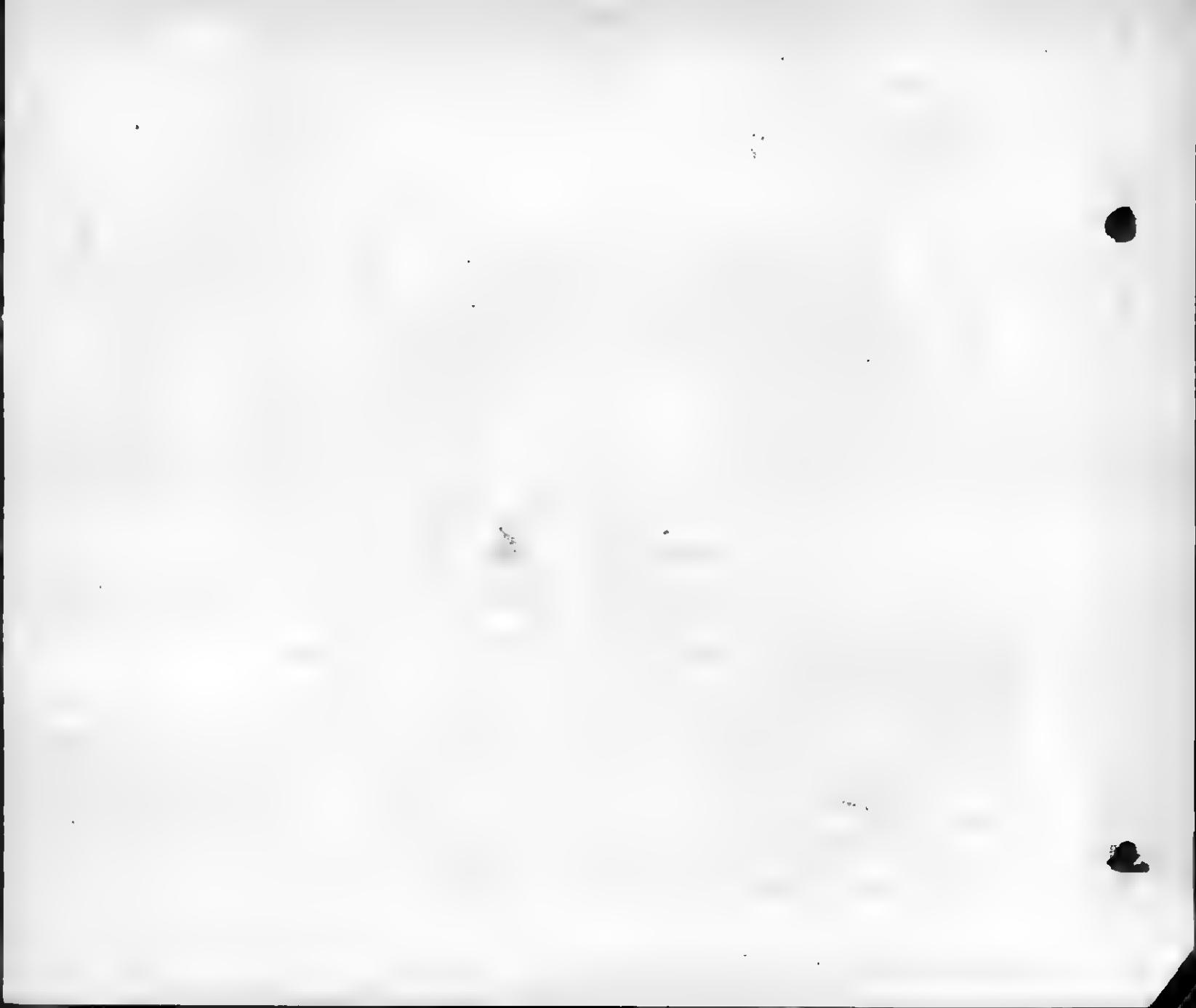


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12320

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>		c. LENGTH OF STAY IN 1B <i>10 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>	
3. NAME OF DECEASED (Type or print) <i>CHARLES H. COOK</i>		First <i>Charles</i>	Middle <i>H.</i>
4. DATE OF DEATH <i>November 19 1958</i>		Last <i>Cook</i>	Month <i>Nov.</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>May 23, 1874</i>		9. AGE (in years from birthdate) <i>84 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gardener</i>	
10c. BIRTHPLACE (State or foreign country) <i>Md.</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
12. FATHER'S NAME <i>Anthony Cook</i>		13. MOTHER'S MAIDEN NAME <i>Elizabeth Miller</i>	
14. ADDRESS <i>Mr. Leslie Cook - Sykesville, Md.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>414-12-1212</i>	
17. INFORMANT <i>Wife</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Hemorrhage into bowel</i> (c) <i>Carcinoma of stomach</i> <i>Gastric ulcer</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Jan 19 1958</i>		20d. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan</i> , 1958, to <i>Nov</i> , 1958, that I last saw the deceased alive on <i>19</i> , 1958, and that death occurred at <i>6:00 P.M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>P. V. Houck Jr.</i> PHYSICIAN'S NAME (Type) <i>P. V. Houck Jr.</i>		ADDRESS (Street, city or town, state) <i>LIBERTY RD. SYKESVILLE, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-22-58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Gravine Park</i>		22d. LOCATION (City, town, or county) <i>Woodlawn Rd., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Father A. Height - Sykesville, Md.</i>		24a. REC'D BY REGISTRAR <i>NOV 25 '58</i>	
ADDRESS <i></i>		24b. REGISTRAR'S SIGNATURE <i>John S. Evans</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12323 CERTIFICATE OF DEATH

12321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westminster		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westminster		d. COUNTY Carroll			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 3 Sullivan Road				d. STREET ADDRESS Route Sullivan Road					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First John	Middle Alonzo	Last Crumbie	4. DATE OF DEATH Nov. 9 1958	Month Nov.	Day 9	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 31, 1884	8. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Crumbie				14. MOTHER'S MAIDEN NAME Kid Orr					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-05-3139		17. INFORMANT Charles Curmbie R. 3 Westminster, Md.			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0				<i>Arteriosclerotic Heart Disease</i>					INTERVAL BETWEEN ONSET AND DEATH 5 yrs
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>influenza</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>influenza</i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Manchester, Md.		(County) Montgomery Co.	(State) Md.
21. I certify that I attended the deceased from 4/11 1958 to Nov 4 1958 that I last saw the deceased alive on Nov 5 1958 , and that death occurred at 6A M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>W.H. Foard</i>		ADDRESS (Street, city or town, state) Manchester, Md. DATE SIGNED 11-10-58							
PHYSICIAN'S NAME (Type) W.H. Foard M.D.		MANCHESTER, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-58		22c. NAME OF CEMETERY OR CREMATORIUM Westminster Cemetery		22d. LOCATION (City, town, or county) Westminster, Maryland			(State)
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Maryland		24a. REC'D BY REGISTRAR Nov 14 '58		24b. REGISTRAR'S SIGNATURE <i>Curmer S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12324

CERTIFICATE OF DEATH

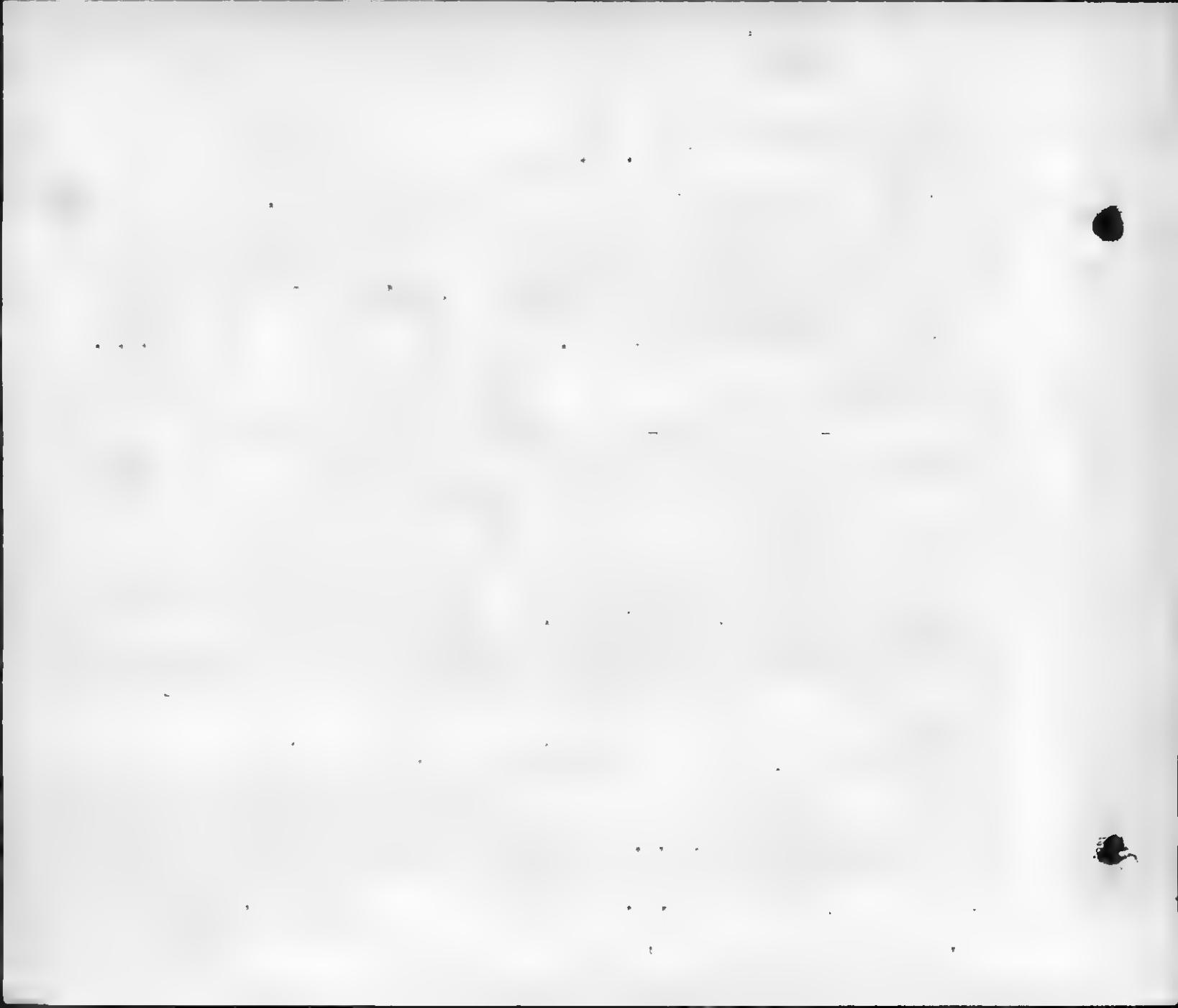
12322

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 17 yrs. 1 mo. 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 603 Greene St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Kathleen	Middle Veronica	Last DAVIS	4. DATE OF DEATH November 12, 1958	Month November	Day 12	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 30, 1894	9. AGE (In years at birthday) 64 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Davis		14. MOTHER'S MAIDEN NAME Mary Cordial					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung abscess with empyema, right lung						INTERVAL BETWEEN ONSET AND DEATH Weeks:	
521X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 , to November 12, 1958 , that I last saw the deceased alive on November 11, 1958 , and that death occurred at 12:01 A.M. , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Springfield State Hospital	
ACTUAL SIGNATURE <i>Agustín del Campo.</i>		M.D.				DATE SIGNED 11/12/58	
PHYSICIAN'S NAME (Type) Agustín del Campo, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/15/58		22c. NAME OF CEMETERY OR CREMATORIUM S. S. Peter & Paul's		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR NOV 17 '58		24b. REGISTRAR'S SIGNATURE <i>Esther L. Thorne</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12325

CERTIFICATE OF DEATH

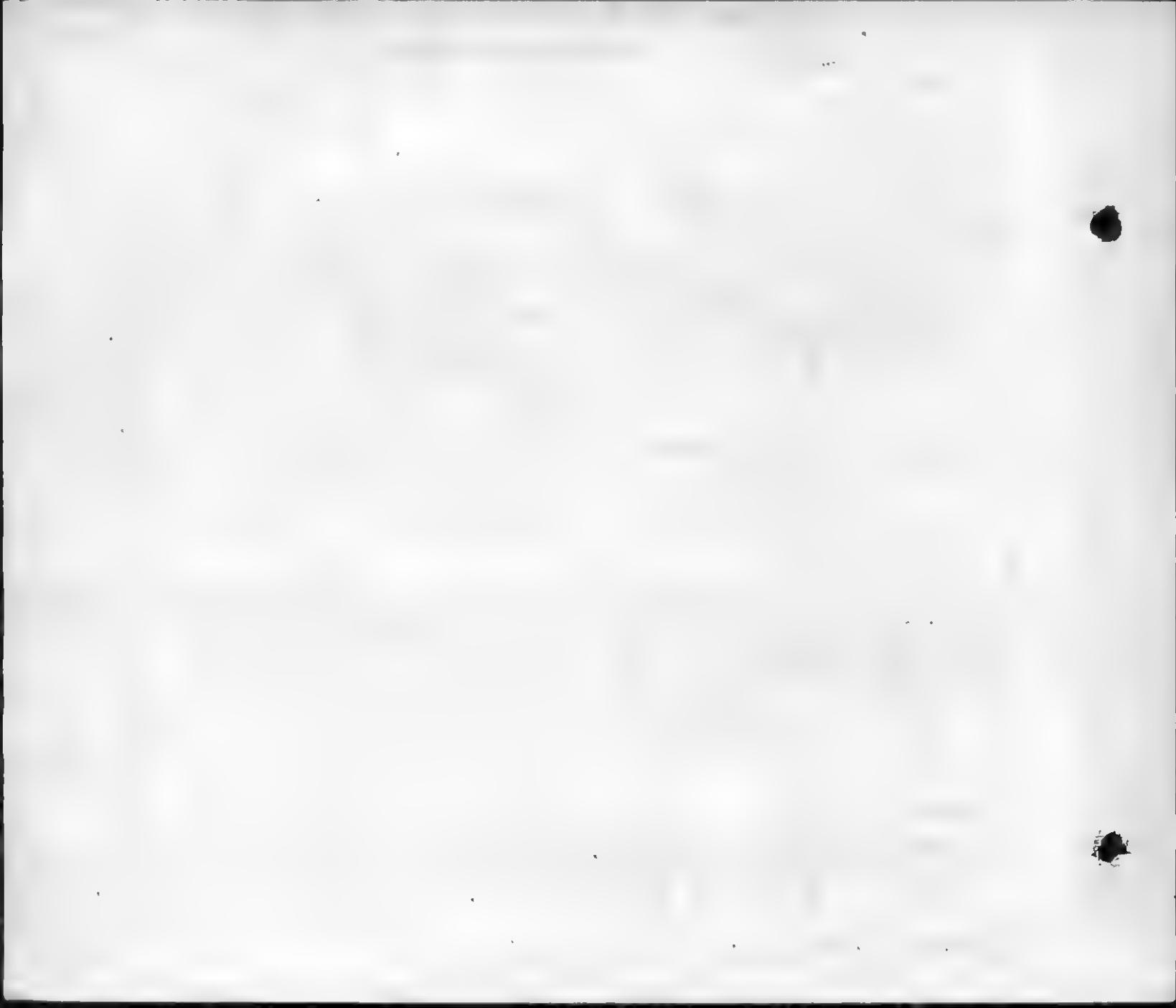
12323

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN 1b 6 Months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1515 Fernley Rd.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Lydia Mary Etzweiler Dockstader	Middle	Last			
4. DATE OF DEATH November	Month	Day	Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH II/II/54			
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR 6 Months	11. IF UNDER 24 HRS. 15 Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Etzweiler		14. MOTHER'S MAIDEN NAME Polly Ritzman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) No		16. SOCIAL SECURITY NO.	17. INFORMANT Elizabeth Conrad Chew 1515 Fernley Rd. Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Address INTERVAL BETWEEN ONSET AND DEATH				
491X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO						
(c) DUE TO						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. associated with Cerebral Arteriosclerosis with Psychotic Reaction		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>10/22/58</u> , 19, to <u>II/1/58</u> , 19, that I last saw the deceased alive on <u>II/1/58</u> , 19, and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Augustin Del Campo.</u> M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/58	22c. NAME OF CEMETERY OR CREMATORIUM Odd Fellows Cem	22d. LOCATION (City, town, or county) Reverton	(State) Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc. 5305 Harford Rd.		ADDRESS		24a. REC'D BY REGISTRAR NOV 5 '58	24b. REGISTRAR'S SIGNATURE John S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be left for the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 so it can be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12324

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Sykesville		c. LENGTH OF STAY IN 1b [Leave blank]		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY C. 7-11	
						c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Sykesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [Leave blank]				d. STREET ADDRESS [Leave blank]				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET		First J.	Middle DURHAM	Last	4. DATE OF DEATH Month Nov.	Month 16,	Day 1958	Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1879	9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? Md.			
13. FATHER'S NAME James Evans McDowell		14. MOTHER'S MAIDEN NAME Ellen (unknown)							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Elizabeth D. Anderson R. I. D. #3, Sykesville		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592 X		DUE TO Nephritis (chronic) Cystitis (obs)		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Arteriosclerosis							
DUE TO Arthritis									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from June , 1958, to Nov. 16, 1958 , that I last saw the deceased alive on 11-10-1958 , and that death occurred at \$130 M , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 103 E Main Westminster 11-16-58		DATE SIGNED	
ACTUAL SIGNATURE Wm C. Jannette									
PHYSICIAN'S NAME (Type) Wm Carl Jannette									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/58		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cem.		22d. LOCATION (City, town, or county) Baltimore, Md.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickens & Sons - Baltimore		ADDRESS 17		24a. REC'D BY REGISTRAR DATE NOV 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12327

CERTIFICATE OF DEATH

12325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 21 yr. 5m. 19d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION Springfield State Hospital		d. STREET ADDRESS -----		d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First CHRIST	Middle -----	Last GEORGE	4. DATE OF DEATH November 30	Month Year 1958	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 64 ? yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? ?		
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Records, Springfield State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH MINUTES Years						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from March 7, 1955, to November 30, 1958, that I last saw the deceased alive on November 30, 1958, and that death occurred at 5:55 AM, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Agustín del Campo, M.D.</i>							ADDRESS (Street, city or town, state) Springfield State Hospital	DATE SIGNED
PHYSICIAN'S NAME (Type)		Sykesville, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Agnes Hospital Board</i>		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank J. Newell, Sykesville, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 5 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12328 CERTIFICATE OF DEATH

12326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 3 yr. 6 mo. 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
f. STREET ADDRESS 417 N. Milton Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Assunta		First Middle Palleschi	Last GIORDANO
4. DATE OF DEATH November 5 1958		Month November	Day 5
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 11-27-82		9. AGE (In years last birthday) 75 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? (Alien) Italy			
13. FATHER'S NAME Peppe (Giuseppe Giordano)		14. MOTHER'S MAIDEN NAME Theresa Maschetti	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO 217-32-555 Hospital records	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 minutes Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 3, 1955, to November 5, 1958, that I last saw the deceased alive on November 5, 1958, and that death occurred at 6:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. Springfield State Hospital DATE SIGNED 11-5-58	
ACTUAL SIGNATURE <i>John Kamm, M.D.</i>		PHYSICIAN'S NAME (Type) Ilse Kamm, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL HOLY REDEEMER		22d. LOCATION (City, town, or county) Baltimore City	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Dellerhoee		24a. REC'D BY REGISTRAR DATE NOV 10 '58	
ADDRESS 322 S High St		24b. REGISTRAR'S SIGNATURE John S. Kamm	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12329

CERTIFICATE OF DEATH

Reg. Dist. No.

12327

1. PLACE OF DEATH a. COUNTY CARROLL SYKESVILLE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 3 yrs 3 mo 1 dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGFIELD STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE, 18	
3. NAME OF DECEASED (Type or print) EDITH		4. DATE OF DEATH GRIMMELL November 2 1958	
5. SEX Female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-9-91	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY Chicago, Illinois	
11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ATWOOD S. FORMAN		14. MOTHER'S MAIDEN NAME EDITH WILSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-07-7651	
17. INFORMANT Katherine Eckert, 18 E. 24th St., Baltimore 18		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO coronary Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS associated w/ circulatory disturbance & cerebral arteriosclerosis & hypertension		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) iotic reaction	
20c. TIME OF INJURY Month, Day, Year Hour o. m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-21-1955 , 19, to 11-2- , 19 58 , that I last saw the deceased alive on November 2 , 19 58 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Elisabeth Knopp		ADDRESS (Street, city or town, state) M.D. Springfield State Hospital Sykesville, Maryland	
PHYSICIAN'S NAME (Type) Elisabeth Knopp		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-5-58	
22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR NOV 5 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12330

CERTIFICATE OF DEATH

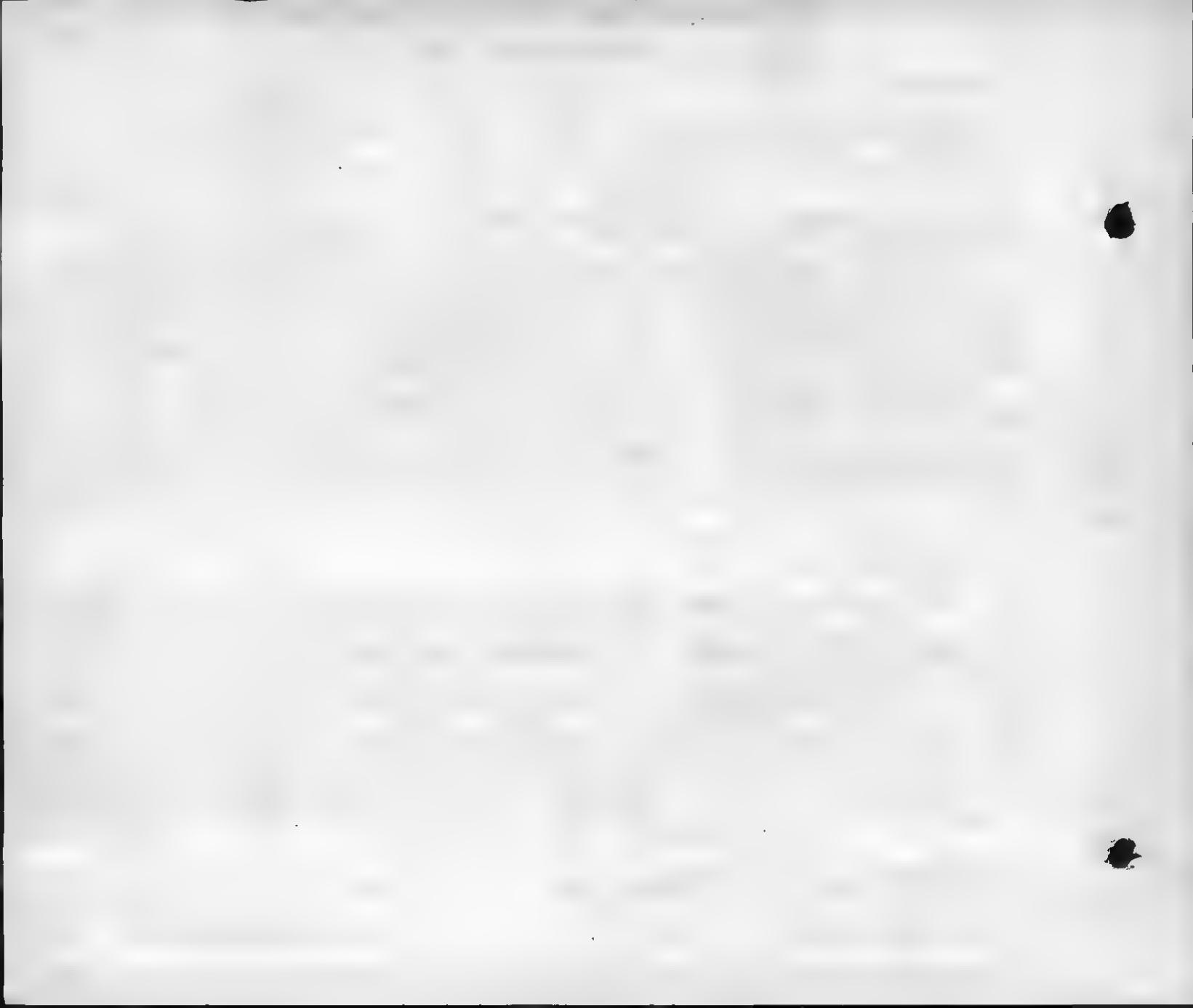
Reg. Dist. No.

12328

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister #4	c. LENGTH OF STAY IN MD 4 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbleton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print), First Middle Last		4. DATE OF DEATH Nov 24 1958	
5. SEX M		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH 11/14/1869	
10a. US LAB OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Allegheny Co Pa USA		12. CITIZEN OF WHAT COUNTRY? Pa USA	
13. FATHER'S NAME Crawford Shearer		14. MOTHER'S MAIDEN NAME Sarah Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT None Harry Lippy Manchester	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 480X Pneumonia (Flu?) DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Tuberculosis DUE TO (c)		19. INTERVAL BETWEEN SET AND DEATH 17 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-07-1958 to 11-24-1958, that I last saw the deceased alive on 11-23-1958, and that death occurred at 1205PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm C Seydel M.D.		ADDRESS (Street, city or town, state) 103 E Main Street Baltimore, Md DATE SIGNED 11-24-58	
PHYSICIAN'S NAME (Type) Wm C Seydel M.D. Westminster, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/26/58	
22c. NAME OF CEMETERY OR CREMATORIAL INSTITUTION St. Peter's Cemetery		22d. LOCATION (City, town, or county) Allegheny Co	
23. FUNERAL DIRECTOR'S SIGNATURE Frederick Becker Hausey Jr.		24a. REC'D BY REGISTRAR ADDRESS 59 DATE NOV 26 '58	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 still attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12331 CERTIFICATE OF DEATH

Reg. Dist. No. 12329

1. PLACE OF DEATH a. COUNTY Carroll			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			b. COUNTY Howard				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c LENGTH OF STAY IN lb 21 days			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups, Maryland							
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						d STREET ADDRESS 14 Sherwood Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOHN			First	Middle	last	4. DATE OF DEATH HARDT			Month	Day	Year		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/13/37			9. AGE (In years lost birthday) 70 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Butcher			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Adam Hardt			14. MOTHER'S MAIDEN NAME Catherine ?			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO 220 01 1927			17. INFORMANT Mrs. Russell Kamps	Address 14 Sherwood Dr., Jessups, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pneumonia 493 X DUE TO												INTERVAL BETWEEN ONSET AND DEATH 10days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)			DUE TO										
DUE TO			(c)										
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Chronic Alcoholism.										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 10/24/ , 19 58 , to 11/2 , 19 58 , that I last saw the deceased alive on 11/2 , 19 58 , and that death occurred at 4 p.m. from the causes and on the date stated above. ACTUAL SIGNATURE <i>JULIAN RADZYHENYEW MD</i>												ADDRESS (Street, city or town, state) 14101 Edmondson Ave.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Nov. 5/58			22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park			22d. LOCATION (City, town, or county) Baltimore 29, Md.			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors			ADDRESS 4101 Edmondson Ave.			24a. REC'D BY REGISTRAR NOV 5 58			24b. REGISTRAR'S SIGNATURE John S. Miller				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12330

12332

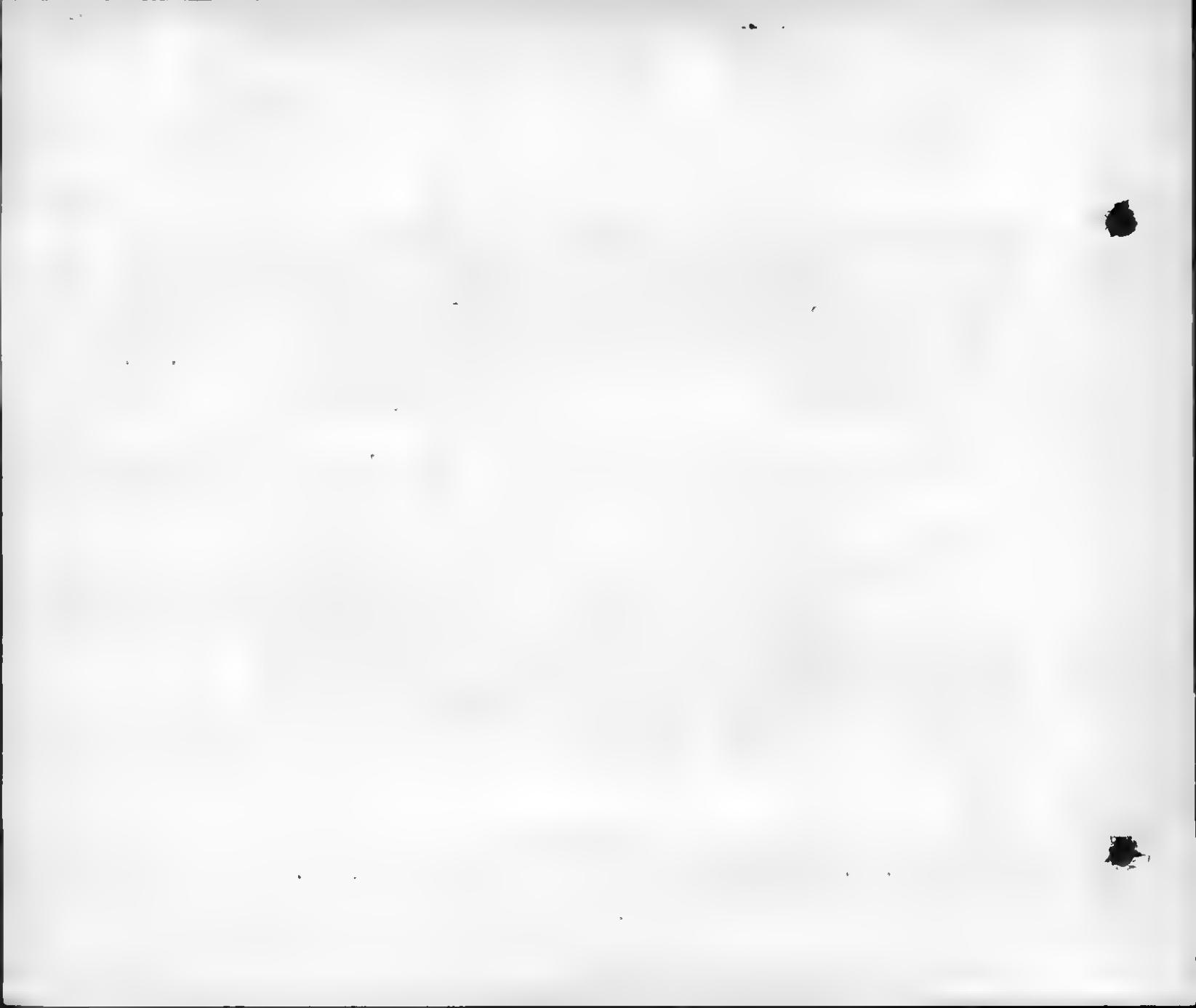
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster		c. LENGTH OF STAY IN TB 12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Harmon	Middle E.	Last Hayden	4. DATE OF DEATH November 17 1958	Month November	Day 17	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1887	9. AGE (In years last birthday) 71 yrs	10. IF UNDER 1 YEAR Months 71	11. IF UNDER 24 HRS Hours 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME John E. Hayden		14. MOTHER'S MAIDEN NAME Martha J. Green						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Mary Hayden, Route #7, Westminster, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Chronic Nephritis						INTERVAL BETWEEN ONSET AND DEATH 5 days		
(b) DUE TO Cerebro-Vascular Accident + Pneumonia						4 yrs		
(c) Hypertension, Vascular						10 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Nov. 12 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Taneytown, Md.		
20f. (City or town) Taneytown, Md.		(County) Carroll		(State) Md.				
21. I certify that I attended the deceased from Aug. 5, 1952 to Nov. 12, 1958 that I last saw the deceased alive on Nov. 12, 1958 , and that death occurred at 5:50 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE E. Ambrose Thompson, M.B., Taneytown, Md.				ADDRESS (Street, city or town, state) Taneytown, Md.		DATE SIGNED 11/19/58		
PHYSICIAN'S NAME (Type) E. A. Thompson								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 20, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Evergreen Mem. Gardens		22d. LOCATION (City, town, or county) Finksburg, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son, Taneytown, Maryland		ADDRESS Taneytown, Maryland		24a. REC'D BY REGISTRAR NOV 21 1958		24b. REGISTRAR'S SIGNATURE John L. Fuss		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12333

CERTIFICATE OF DEATH

12331

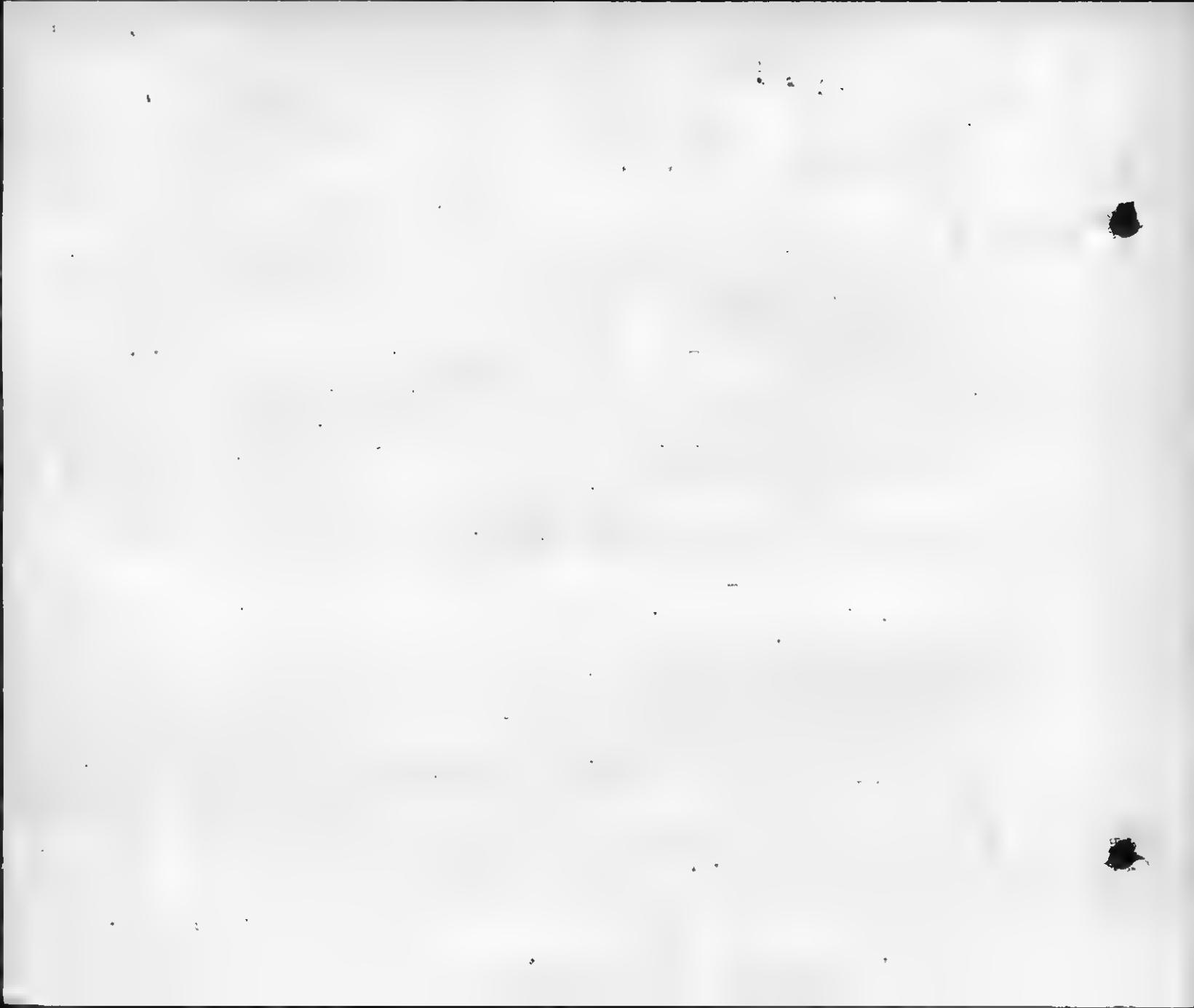
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 7mo. 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Toivo		First Rudolph	Middle Heleen
4. DATE OF DEATH 11 9 1958		Month Month	Day Day
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-17-1910	
9. AGE (In years last birthday) 48 yrs		10. IF UNDER 1 YEAR Months Months	
11. IF UNDER 24 HRS. Days Days		12. IF UNDER 24 HRS. Hours Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Seaman		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emil Heleen		14. MOTHER'S MAIDEN NAME Jennie Lahti	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 022-10-9516	
17. INFORMANT Hospital Records, Springfield State Hospital Sykesville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH minutes	
DUE TO 440.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis		months	
DUE TO —			
(c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with other diseases of unknown or uncertain cause, with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —	
(County) —		(State) —	
21. I certify that I attended the deceased from 3-22-1958 , 19 — , to 11-9-1958 , 19 — , that I last saw the deceased alive on 11-9-1958 , 19 — , and that death occurred at 8:10 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 11-10-1958	
ACTUAL SIGNATURE Walter Knopp, M.D.		PHYSICIAN'S NAME (Type) Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-14-58	
22c. NAME OF CEMETERY OR CREMATORIUM Center Cemetery		22d. LOCATION (City, town, or county) West Wareham, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	24a. REC'D BY REGISTRAR NOV 13 '58
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1-3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12334

CERTIFICATE OF DEATH

12332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>			2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Maryland</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Sykesville</u>			c. LENGTH OF STAY IN 1b <u>1lyr. 3mo. 19days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>			e. STREET ADDRESS <u>925 S. Fremont Ave. Balt. 30, Md.</u>		
3. NAME OF DECEASED (Type or print) <u>John Joseph Hessian</u>			4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1958</u>		
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH <u>5-21-1888</u>		
9. AGE (In years lost/birthday) <u>70 yrs.</u>			10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Odd Jobs</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-unk</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John J. Hessian</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		
17. INFORMANT <u>Hospital Records</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic brain syndrome associated with disturbance of metabolism</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>growth or nutrition with senile brain disease, without qualifying phrase</u>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>August 19 55</u> to <u>Nov. 14 1958</u> , that I last saw the deceased alive on <u>Nov. 14 1958</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Walter Knopp</u>			ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>11-17-58</u>		
PHYSICIAN'S NAME (Type) <u>Walter Knopp, M.D.</u>			Sykesville, Maryland		
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-19-58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>New Cathedral</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Wright</u>			ADDRESS <u>Sykesville, Md.</u>		
24a. REC'D BY REGISTRAR <u>NOV 20 '58</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur A. Knopp</u>		

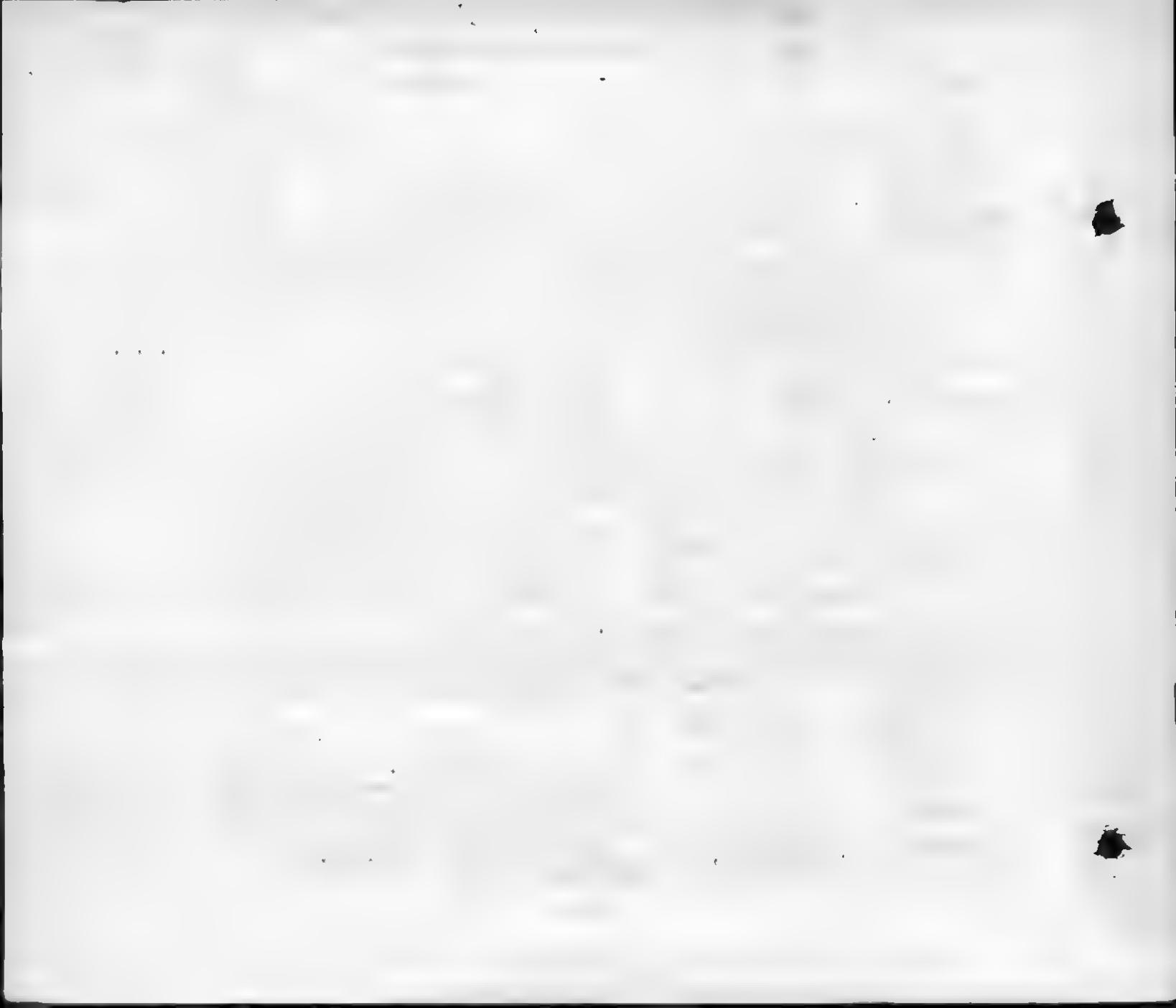


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12335 Item 1c File CERTIFICATE OF DEATH

Reg. Dist. No. 12333

1. PLACE OF DEATH o COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland		b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c LENGTH OF STAY IN 1b 11 Y 4 M 6 D		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond		d. STREET ADDRESS Box 95			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Myrtle Howard Ireland		First Middle Last		4. DATE OF DEATH November 23 1958		Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/90	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	11. KIND OF BUSINESS OR INDUSTRY -	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James F. Ireland		14. MOTHER'S MAIDEN NAME Catherine Woorell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis 702X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Psychosis with mental deficiency.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) -		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	
20f. (City or town) -		(County) -		(State) -					
21. I certify that I attended the deceased from March 7 1955 to November 23 1958 , that I last saw the deceased alive on November 23 1958 , and that death occurred at 8:06a.m. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Springfield State Hospital									
DATE SIGNED 11/23/58									
ACTUAL SIGNATURE Agustín del Campo		M.D.		Sykesville, Md.					
FATHER'S NAME (Type) Agustín del Campo, M.D.		ADDRESS							
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/26/58		22b. DATE THEREOF 11/26/58		22c. NAME OF CEMETERY OR CREMATORIUM J. G. Millaydown Rd.		22d. LOCATION (City, town, or county) Baltimore Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frank E. Newell, Sykesville, Md.		ADDRESS		24a. REC'D BY REGISTRAR REG 1 '58		24b. REGISTRAR'S SIGNATURE John S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12336

CERTIFICATE OF DEATH

Reg. Dist. No.

12334

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 V O I - 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS 1804 Maryland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edward	Middle	Last Johnson	4. DATE OF DEATH	Month November	Day 11	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-1893	9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Gloucester Co., Va.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Johnson		14. MOTHER'S MAIDEN NAME Alice Moody					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Edward Johnson - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular insufficiency <i>4 d x 1</i>		DUE TO Gangrenous pneumonia				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Gangrenous pneumonia					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Henryton	(County) Ann Arbor	(State) Michigan
21. I certify that I attended the deceased from November 10, 1958 , to November 11, 1958 , that I last saw the deceased alive on November 11, 1958 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Henryton, Maryland		DATE SIGNED 11-11-58	
ACTUAL SIGNATURE <i>E. M. Maculans</i>	M.D.						
PHYSICIAN'S NAME (Type) Edgar M. Maculans, M.D.					Henrton State Hospital, Henrton, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 18 1958	22c. NAME OF CEMETERY OR CREMATORIAL Cemetery	22d. LOCATION (City, town, or county) Ann Arbor, County, MI.	(State) Michigan			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Habbed</i>	ADDRESS 98 Drury Rd	24a. REC'D BY REGISTRAR DATE NOV 17 1958	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12305

CERTIFICATE OF DEATH

Reg. Dist. No.

12335

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 3 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 43 UNION ST		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER	
f. STREET ADDRESS 143 UNION ST		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle IRENE	Last JONES
4. DATE OF DEATH	Month NOV. 10	Day 1958	Year
5. SEX F	6. COLOR OR RACE COL	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 31- 1888
9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
10c. BIRTHPLACE (State or foreign country) MARYLAND		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM MILBERRY		14. MOTHER'S MAIDEN NAME MARTHA BRIGHFELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT DOROTHY SMITH WESTMINSTER MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Syphilitic cardio. vascular disease Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c), stating the underlying cause lost. 2 days (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Heart was decompensated		INTERVAL BETWEEN ONSET AND DEATH 8 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1958	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1958 to Nov. 10, 1958 that I last saw the deceased alive on Nov. 10, 1958 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE G. Reese Wilkens		ADDRESS (Street, city or town, state) 15 Remington Ave 11/10/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/13/58	
22c. NAME OF CEMETERY OR CREMATORIUM MT JOY		22d. LOCATION (City, town, or county) (State) UNIONTOWN MD	
23. FUNERAL DIRECTOR'S SIGNATURE O'Hartigan & Sons Union Bridge Md		24a. REC'D BY REGISTRAR DATE NOV 14 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be retained by the hospital or attending physician. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

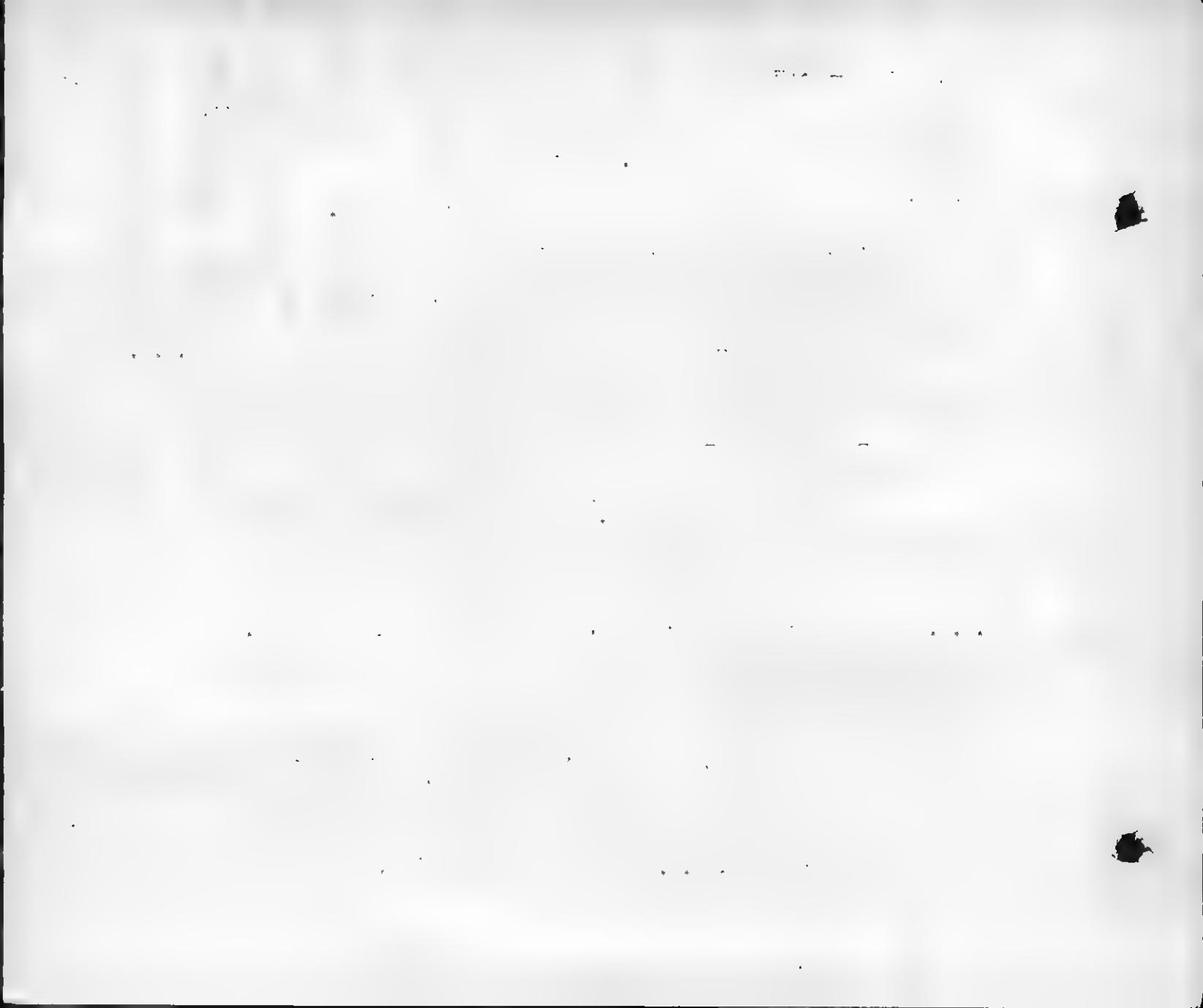
12337

CERTIFICATE OF DEATH

12336

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 11mos. 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1302 Hillman St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Michael	Middle Edward	Last Judge	4. DATE OF DEATH	Month November	Day 20	Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 28, 1869		9. AGE (In years lost birthday) 89 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - RETIRED		10b. KIND OF BUSINESS OR INDUSTRY - BALTO. CITY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME PATRICK JUDGE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 44-57 (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. due to cerebral arteriosclerosis with psychotic reaction.								
19. MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		20c. TIME OF INJURY Hour a.m. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Springfield	(County) Maryland	(State) MD
21. I certify that I attended the deceased from July 1, 1958 , to November 20 1958 , that I last saw the deceased alive on November 20, 1958 , and that death occurred at 10:06PM , from the causes and on the date stated above. ACTUAL SIGNATURE: <i>Ellis Margolin</i> M.D. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/21/58								
PHYSICIAN'S NAME (Type)		Ellis Margolin, M.D. Sykesville, Maryland						
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-25-1958		22c. NAME OF CEMETERY OR CREMATORIUM CATHEDRAL		22d. LOCATION (City, town, or county) (State) BALTO. MD.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Walter Conklin</i>		ADDRESS 5444 BELAIR RD.		24a. REC'D BY REGISTRAR DMV 25 '58		24b. REGISTRAR'S SIGNATURE C. T. J. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12306

CERTIFICATE OF DEATH

Reg. Dist. No.

12337

1. PLACE OF DEATH a. COUNTY CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE M.D.		b. COUNTY CARROLL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 20 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 68 1/2 BONO ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle HOWARD	Last KEEFER	4. DATE OF DEATH 11 / 16 / 1958	Month	Day	Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH JUNE 25 1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) CARROLL COUNTY MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME CALVIN KEEFER		14. MOTHER'S MAIDEN NAME FANNIE B. OTTO		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		Address 39 W. GREEN ST. WESTMINSTER, MD.		
16. SOCIAL SECURITY NO 217-28-1057		17. INFORMANT Son HOWARD S. KEEFER		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO Coronary Thrombosis Chronic Hypertension Arteritis Sclerotic & Bronchial Asthma		INTERVAL BETWEEN ONSET AND DEATH 10 days Several years 40		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21. I certify that I attended the deceased from Nov 15, 1958 to Nov 16, 1958 , that I last saw the deceased alive on Nov 15, 1958 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE W. Glenn Speicher PHYSICIAN'S NAME (Type)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/19/58		22c. NAME OF CEMETERY OR CREMATORIAL MEADOW BRANCH CEM.		22d. LOCATION (City, town, or county) WESTMINSTER MD.		
23. FUNERAL DIRECTOR'S SIGNATURE James H. Buffell		ADDRESS 2548 Main St. Westminster, Md.		24a. REC'D BY REGISTRAR DATE NOV 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12338

CERTIFICATE OF DEATH

12338

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 sheet 3 detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 311	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGFIELD STATE Hosp.				d. STREET ADDRESS 934 Ashland Court, Baltimore 2, Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First CATHERINE	Middle ANNA	Last KIRMES	4. DATE OF DEATH	Month 10 Day 11 Year 1958
5. SEX FEMALE	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore Md	
13. FATHER'S NAME NICHOLAS Schonberg		14. MOTHER'S MAIDEN NAME HENRIETTA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT HOSPITAL RECORDS Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4410 A DUE TO URACHEMIC COMA INTERVAL BETWEEN ONSET AND DEATH 34 hrs					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Arteriosclerotic vascular disease of years			
		(c) General Arteriosclerosis		11	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 - 3, 1955, to 11 - 7, 1958, that I last saw the deceased alive on 11 - 7, 1958, and that death occurred at 8:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED RITA S. GLAHN M.D. Springfield State Hosp 11-7-58					
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) RITA S. GLAHN			
22a. BURIAL, CREMATION, EMBALMING (Specify)		22b. DATE THEREOF 11/11/58		22c. NAME OF CEMETERY OR CREMATORIAL Holy Rosaceous Catholic Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 10 '58	
F. Gilleyport - 1300 East Carroll				24b. REGISTRAR'S SIGNATURE C. J. S. Glahn	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

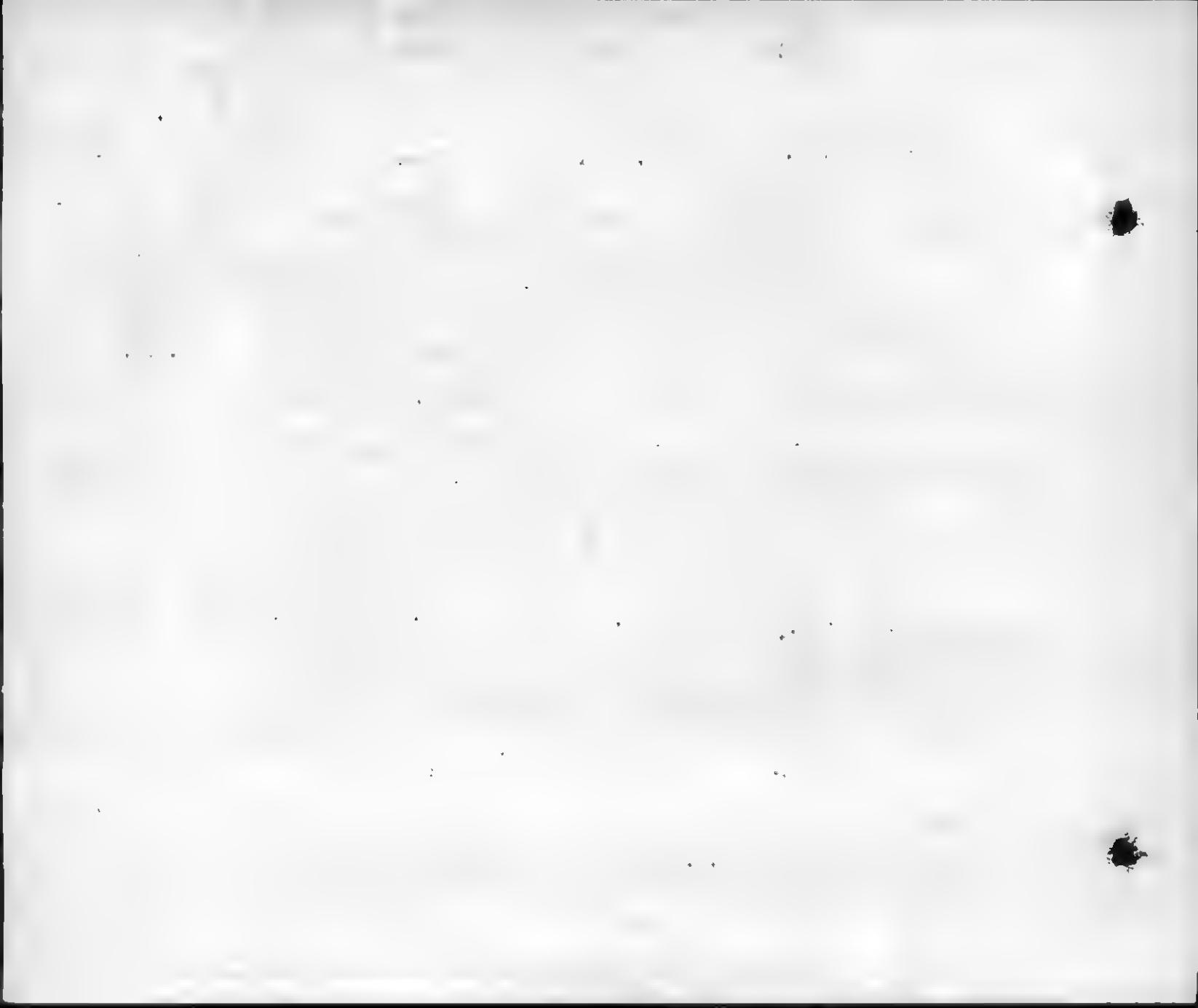
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12339

CERTIFICATE OF DEATH

Reg. Dist. No. 12339

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 43 yrs. 4 mos. 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Joseph	Middle 	Last Knight
4. DATE OF DEATH	Month November	Day 13,	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1891
9. AGE (In years lost birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Days 	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Elmerick	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Sliscer Knight	14. MOTHER'S MAIDEN NAME Mary N. Carroll	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No	16. SOCIAL SECURITY NO. - - -	17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 354X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Unknown			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenia, hebephrenic type. Pulmonary tuberculosis, far advanced, active.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 27, 1958 to November 13, 1958 , that I last saw the deceased alive on November 12, 1958 , and that death occurred at 12:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Julian Radd, M.D.</i> DATE SIGNED 11/13/58			
PHYSICIAN'S NAME (Type) Julian Radd, M.D.	Sykesville, Maryland		
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-15-58	22c. NAME OF CEMETERY OR CREMATORIUM Springfield	22d. LOCATION (City, town, or county) Sykesville, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Julian Radd, Sykesville, Md.</i>	ADDRESS Sykesville, Md.	24a. REC'D BY REGISTRAR DATE NOV 17 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12340

CERTIFICATE OF DEATH

12340

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14	
3. NAME OF DECEASED (Type or print) Carl		d. STREET ADDRESS 6114 Glenoak Ave.	
4. DATE OF DEATH November 3, 1958		e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 12, 1897
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE CITY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Krauss		14. MOTHER'S MAIDEN NAME Marilyn Burry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced, active INTERVAL BETWEEN ONSET AND DEATH Years 002 X			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with circ. dist., with psychotic reaction, plus pulmonary tuberculosis. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Baltimore (County) Maryland (State) MD	
21. I certify that I attended the deceased from October 22, 1958 to November 3, 1958 , that I last saw the deceased alive on November 3, 1958 , and that death occurred at 6:53 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ellis S. Margolin</i>		ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 11/4/58	
PHYSICIAN'S NAME (Type) Ellis S. Margolin, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-7-58		22b. DATE THEREOF 11-7-58	
22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town, or county) Baltimore (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Luck</i>		ADDRESS 5305 Hayford	
24a. REC'D BY REGISTRAR DATE 11/4/58		24b. REGISTRAR'S SIGNATURE <i>Leonard J. Luck</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12341

CERTIFICATE OF DEATH

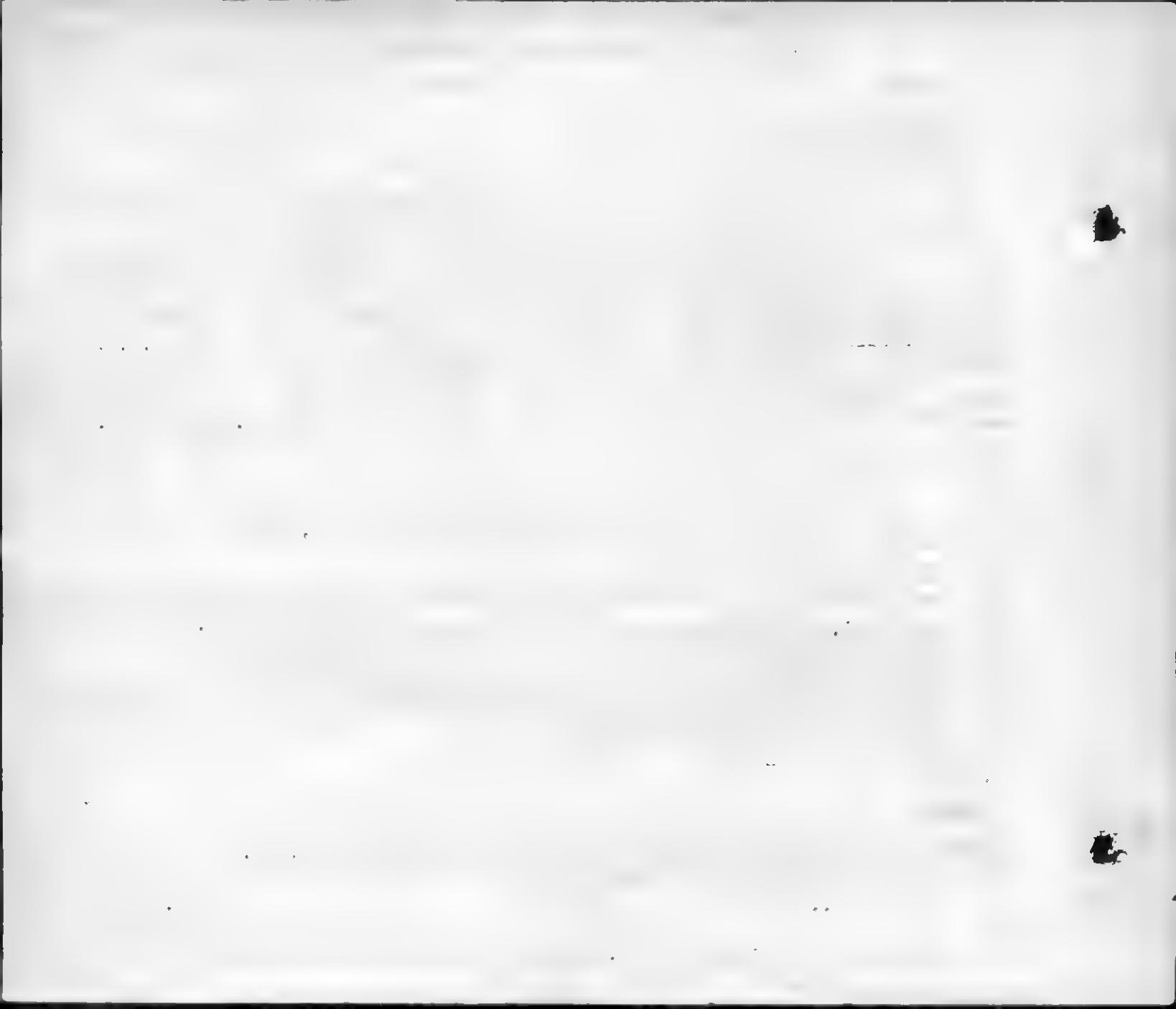
Reg. Dist. No.

12341

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 8779 Philadelphia Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Frederick	Middle	Last Kreisel	4. DATE OF DEATH 11	Month 11	Day 26	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-6-1871	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 87	IF UNDER 24 HRS Days 87	Hours 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith---Retired		10b. KIND OF BUSINESS OR INDUSTRY Balcksmith		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Kreisel		14. MOTHER'S MAIDEN NAME Unknown Hansge					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. *****		17. INFORMANT Edwin Kreisel, Son, Address			
				1129 S. Hanover St., Baltimore 30, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH years	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Chronic rheumatic heart disease					
		Old fibrotic pulmonary tuberculosis, healed				years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS associated with senile brain disease, with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-5-58 , 19, to 11-26-, 1958 , that I last saw the deceased alive on 11-26-, 1958 , and that death occurred at 10:15 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Springfield State Hospital	
ACTUAL SIGNATURE <i>Agustin del Campo</i>		DATE SIGNED 11-26-58					
PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF NOV 29, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lassahn Funeral Home</i>		ADDRESS 7701 Belair Rd.		24a. REC'D BY REGISTRAR NOV 2 B '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12342

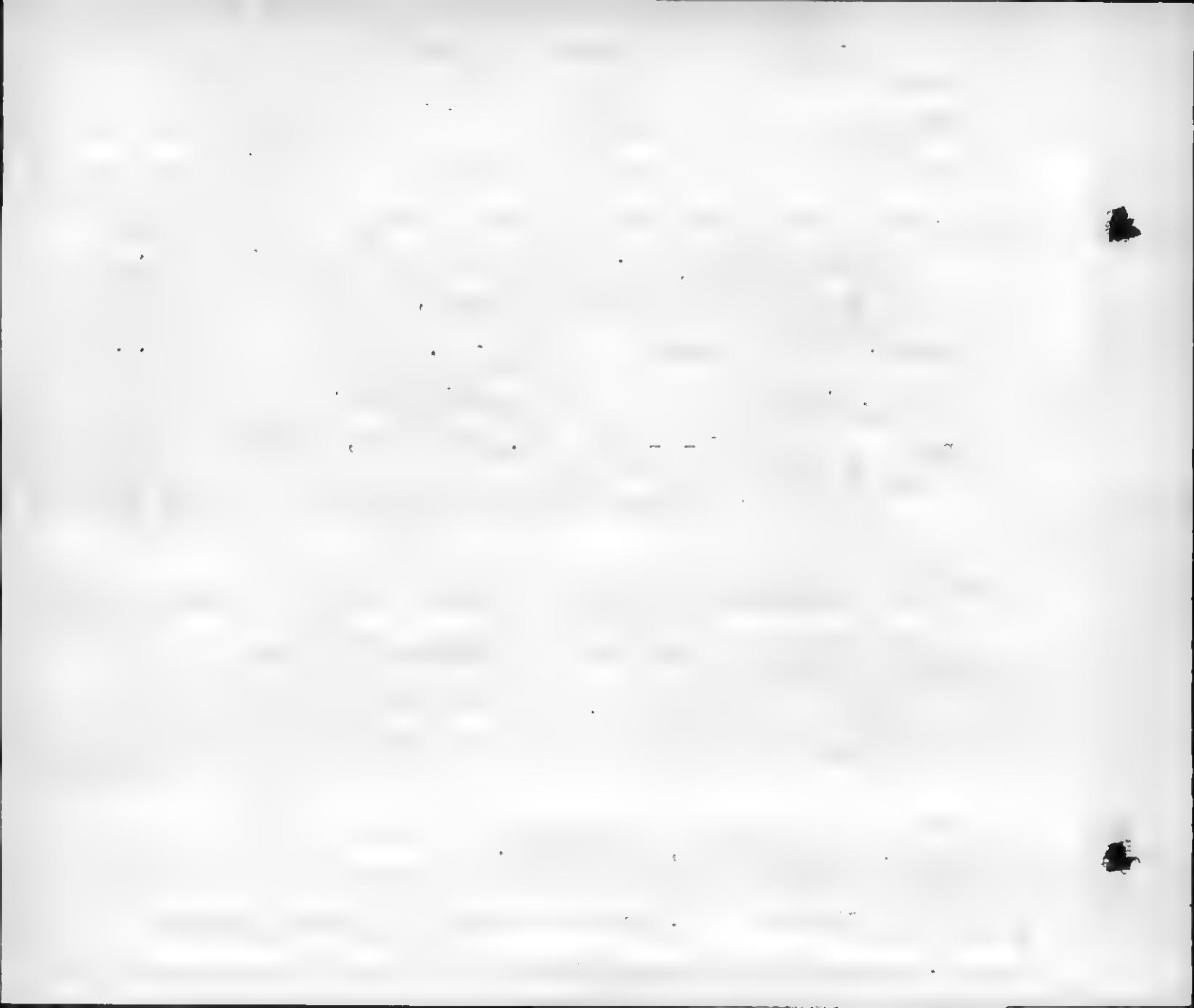
CERTIFICATE OF DEATH

12342

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

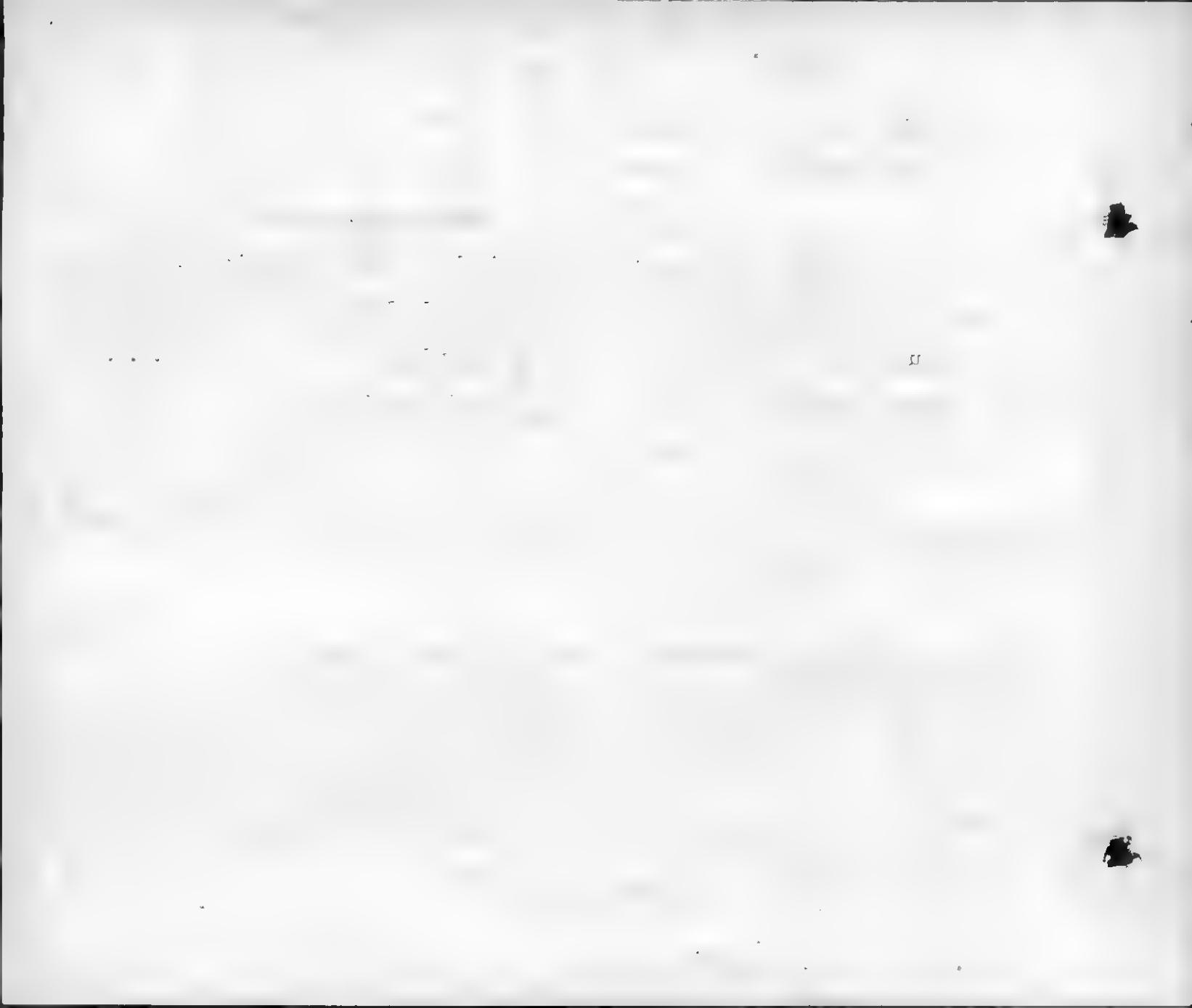
1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		c. LENGTH OF STAY IN lb 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Taneytown		d. STREET ADDRESS /			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) David		First M.	Middle Little	Last 	4. DATE OF DEATH November 7, 1958	Month November	Day 7	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1880		9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker		10b. KIND OF BUSINESS OR INDUSTRY Cemetery		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry S. Little				14. MOTHER'S MAIDEN NAME Sarah Englebert					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-05-2073		17. INFORMANT Mrs. David Little, Taneytown, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Taneytown		(County) 	(State)
21. I certify that I attended the deceased from Jan 6, 1958 , to Nov 7, 1958 , that I last saw the deceased alive on Nov 5, 1958 , and that death occurred at 1:30 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 			
ACTUAL SIGNATURE E. Ambler Thompson, M.D., Taneytown, Md.						DATE SIGNED 11/7/58			
PHYSICIAN'S NAME (Type) E. Ambler Thompson, Taneytown, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/58		22c. NAME OF CEMETERY OR CREMATORIUM St. Joseph's Cemetery		22d. LOCATION (City, town, or county) Taneytown, Maryland		(State) 	
23. FUNERAL DIRECTOR'S SIGNATURE G. O. Fuss & Son		ADDRESS Taneytown, Maryland		24a. REC'D BY REGISTRAR NOV 10 '58		24b. REGISTRAR'S SIGNATURE C. L. Thompson			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 1 Fil 775 11-17-58 e										12343		12343				
CERTIFICATE OF DEATH										Reg. Dist. No.						
1. PLACE OF DEATH a. COUNTY Carroll					2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Maryland					b. COUNTY Carroll						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown					c. LENGTH OF STAY IN 1b 3 weeks					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "At home of Niece."					d. STREET ADDRESS West Baltimore Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Lydia	Middle Ann	Last Little	4. DATE OF DEATH November 8, 1958	Month Day Year	Month Day Year	Month Day Year								
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 21, 1870		9. AGE (in years last birthday) 88 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Own home			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY U.S.A.							
13. FATHER'S NAME Henry Aulhouse					14. MOTHER'S MAIDEN NAME Martha Angell											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none			17. INFORMANT Mr. Carroll Newcomer, Taneytown, Maryland			Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis & hypercarded degeneration DUE TO 42 d.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO (c) Sensitivity										INTERVAL BETWEEN ONSET AND DEATH 5 years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that I attended the deceased from 8-17 , 19 57 , to 11-8 , 19 58 , that I last saw the deceased alive on 11-8- , 19 58 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Leonard L. Potter M.D. 12 W. KING ST. LITTLESTOWN, PA						
ACTUAL SIGNATURE Leonard L. Potter			DATE SIGNED 11-10-58													
PHYSICIAN'S NAME (Type) LEONARD L. POTTER			22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							22b. DATE THEREOF 11/11/58			22c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery		22d. LOCATION (City, town, or county) Taneytown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son, Taneytown, Maryland			24a. REC'D BY REGISTRAR ADDRESS Arthur & Thane							24b. REGISTRAR'S SIGNATURE						
			DATE NOV 12 '58													



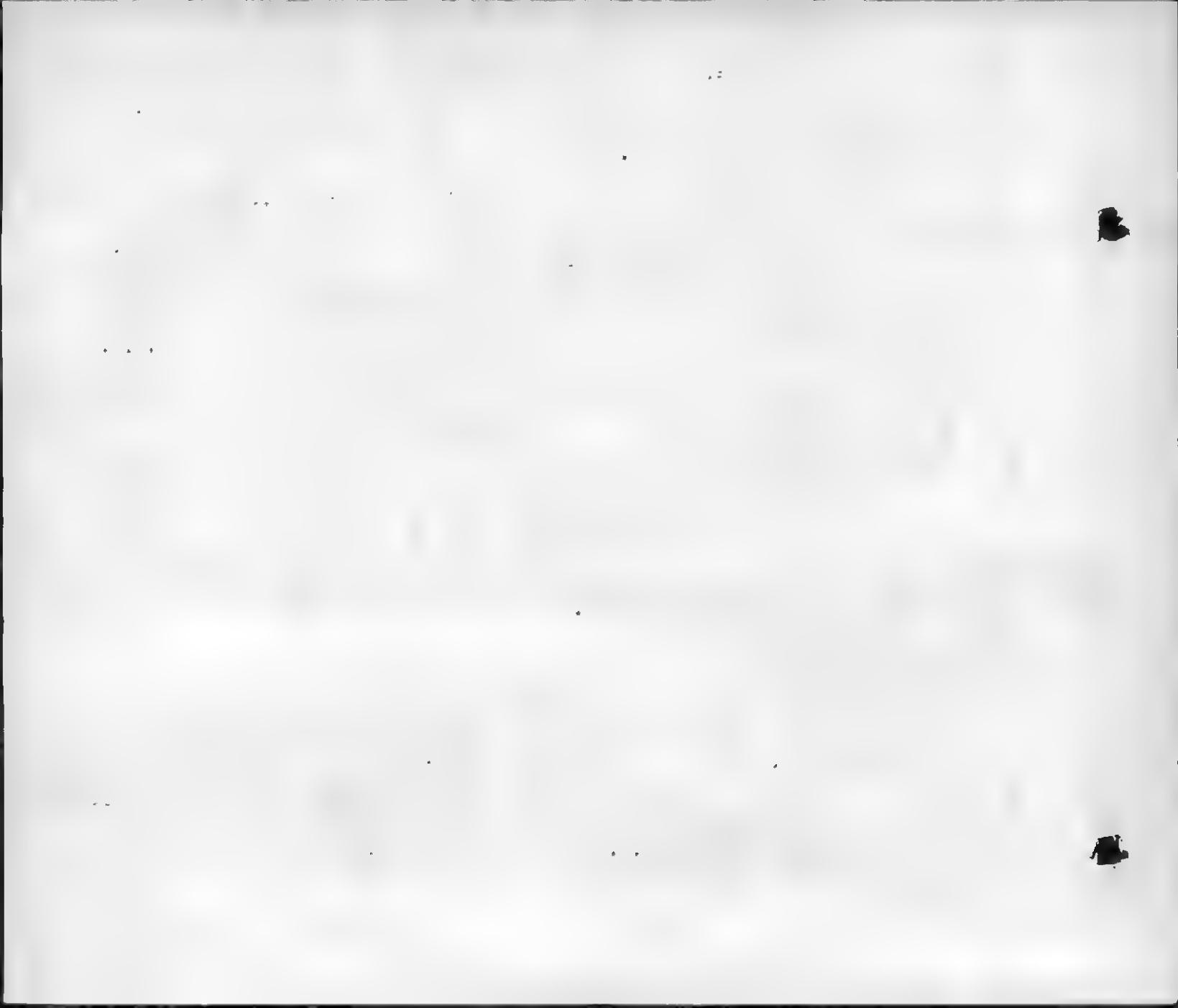
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12344

CERTIFICATE OF DEATH

Reg. Dist. No. 12344

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 mos. 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Lillian Elizabeth		d. STREET ADDRESS 4100 Glenmore Ave., Zone 6	
4. SEX Female	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH February 13, 1912
8. AGE (In years less birthday) 46 yrs.	9. IF UNDER 1 YEAR Months 7	10. IF UNDER 24 HRS. Days 19	11. Month November
12. Day 19, 1958	13. FATHER'S NAME John Lunz	14. MOTHER'S MAIDEN NAME Unknown	15. CITIZEN OF WHAT COUNTRY? U.S.A.
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	17. SOCIAL SECURITY NO - - -	18. INFORMANT Springfield Hospital Records	Address
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cardiac hypertrophy (c)			
INTERVAL BETWEEN ONSET AND DEATH Weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Depressive reaction with psychosis.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 15, 1958 , to November 19, 1958 , that I last saw the deceased alive on November 18, 1958 , and that death occurred at 2:00A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustín del Campo</i>			ADDRESS (Street, city or town, state) Springfield State Hospital
PHYSICIAN'S NAME (Type) Agustín del Campo, M.D.			DATE SIGNED 11/19/58
22a. BURIAL, Cremation, (Specify) Burial	22b. DATE THEREOF 11/22/58	22c. NAME OF CEMETERY OR CREMATORIUM Parkwood	22d. LOCATION (City, town or county) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Carl B. Wolverton Funeral Home Inc.		ADDRESS 6304 Belair Rd., Baltimore, Md.	24a. REC'D BY REGISTRAR DATE NOV 24 58
			24b. REGISTRAR'S SIGNATURE Carl B. Wolverton



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 so it can be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

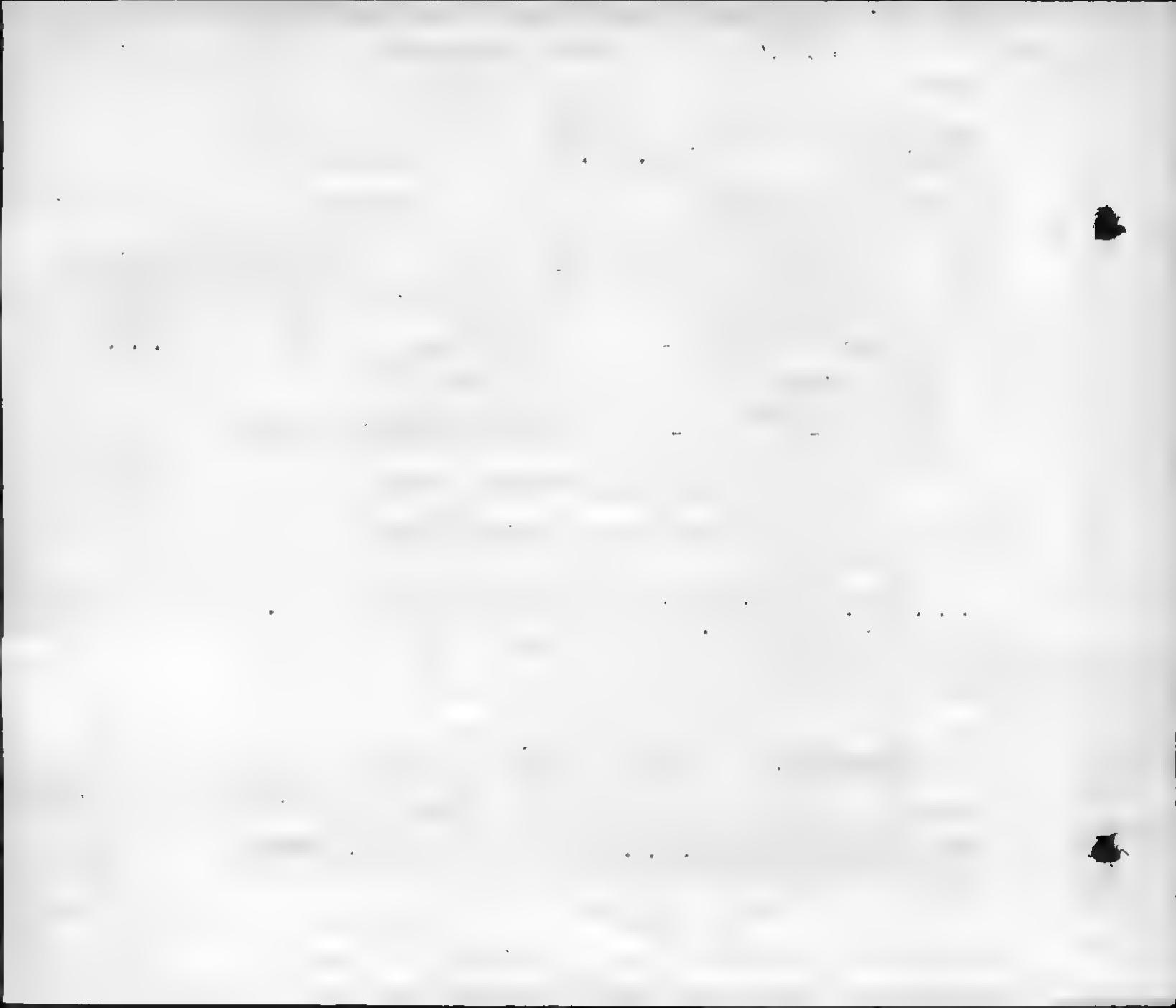
12345

CERTIFICATE OF DEATH

Reg. Dist. No.

12345

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 yr. 9 mos. 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
3. NAME OF DECEASED (Type or print) Mary		First Rebecca	Middle MAKINSON
4. SEX Female	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH October 15, 1875
8. AGE (In years less birthday) 83 yrs.		9. IF UNDER 1 YEAR <input type="checkbox"/> Months <input type="checkbox"/> Days	10. IF UNDER 24 HRS. <input type="checkbox"/> Hours <input type="checkbox"/> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shirtmaker		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Makinson		14. MOTHER'S MAIDEN NAME Agnes Isaac	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No, unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Generalized arteriosclerosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with senile brain disease with psychotic reaction.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fracture, left humerus.	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. 19 <input type="checkbox"/> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <input type="checkbox"/> (State) <input type="checkbox"/>	
21. I certify that I attended the deceased from January 17, 1958 , to November 12, 1958 , that I last saw the deceased alive on November 12, 1958 , and that death occurred at 1:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i>		ADDRESS (Street, city or town, state) Springfield Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 11/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-15-58	
22c. NAME OF CEMETERY OR CREMATORIUM ST JOHNS		22d. LOCATION (City, town, or county) ELICOTT CITY MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F.E. Hyattelline Ellicott City Md.</i>		ADDRESS Ellicott City Md.	
		24a. REC'D. BY REGISTRAR NOV 18 1958	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traub</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be rejoined by the hospital or attending physician.
TO FUNER [REDACTED] After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 & 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

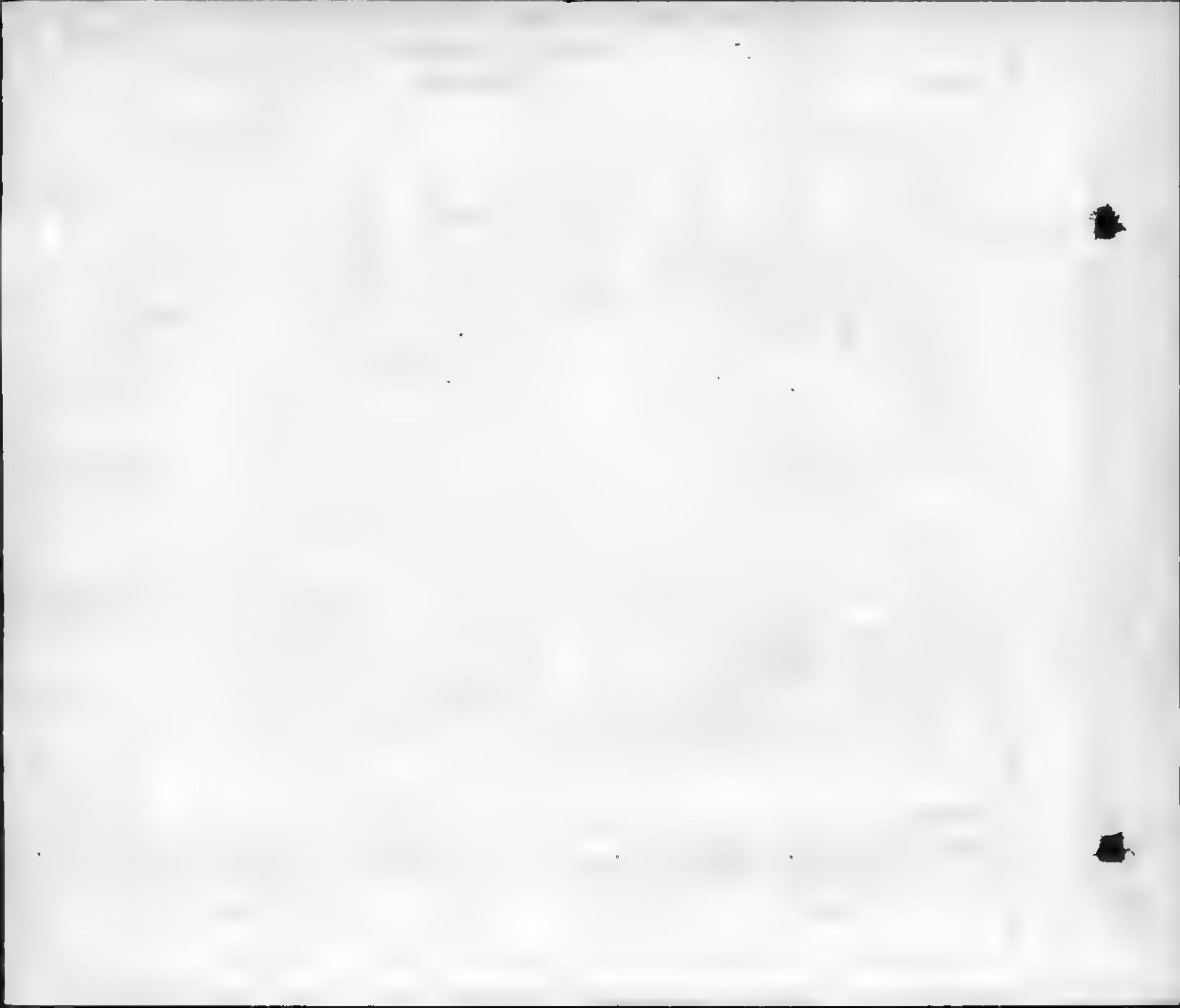
12346

CERTIFICATE OF DEATH

12346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN lb 248 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
3. NAME OF DECEASED (Type or print) First Sandy		4. DATE OF DEATH Nov 29 Month Day Year McCoy 1958					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-5-1909				
9. AGE (In years lost birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemical Mixer		10b. KIND OF BUSINESS OR INDUSTRY					
10c. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Sandy McCoy, Sr.		14. MOTHER'S MAIDEN NAME Margaret Rupper					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO.					
17. INFORMANT Sandy McCoy - Patient		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 003.0							
DUE TO Cerebro-vascular Disease							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.							
(b) Old Tuberculous Pleurisy and Potts disease of							
DUE TO							
(c) Lumbar Spine (five)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I attended the deceased from March 26, 1958, to November 29, 1958, that I last saw the deceased alive on November 29, 1958, and that death occurred at 10:15A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Henryton, Maryland		DATE SIGNED 11-29-58	
ACTUAL SIGNATURE <i>E. M. Maculans</i>		M.D.					
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M.D.				Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/58		22c. NAME OF CEMETERY OR CREMATORIUM Mt Auburn		22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Straus</i>		ADDRESS 400 E. 30th St. between Avenue L and K		24a. REC'D BY REGISTRAR DATE 12/1/58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Straus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

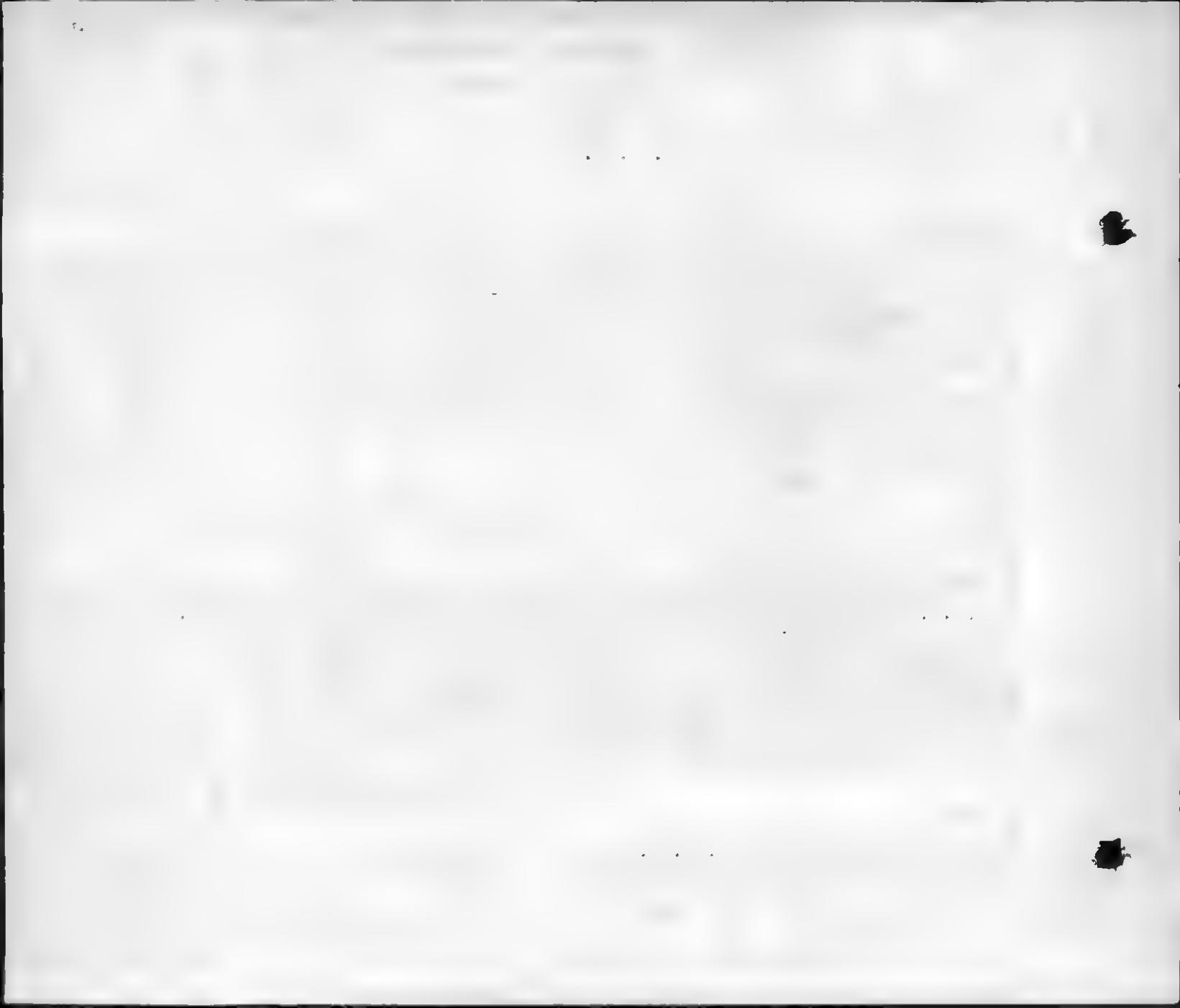
12347

CERTIFICATE OF DEATH

12347

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 34y. 7m. 6d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS -----	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ANNIE	Middle TERESA	Last MEYERS	4. DATE OF DEATH November 29	Month	Day	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-28-78	9. AGE (In years less birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours	12. IF UNDER 24 HRS. Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Homel		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Meyers		14. MOTHER'S MAIDEN NAME Theresa Hartman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO 7-12-12		17. INFORMANT Record, Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH Years	
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. associated with convulsive disorder, without qualifying phrase. Mental deficiency, undifferentiated						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hospital		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-20-54 , 19, to 11-29-58 , 19, that I last saw the deceased alive on November 29 , 1958, and that death occurred at 8:45 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Edmund Lusthaus		M.D.		Springfield State Hospital		DATE SIGNED	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M. D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-3-58		22c. NAME OF CEMETERY OR CREMATORIAL New Cathedral		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight		ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE DEC 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12348

CERTIFICATE OF DEATH

Reg. Dist. No.

12348

1. PLACE OF DEATH o. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patapsco		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patapsco		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Bessie	Middle Morgan	Last Myerly	4. DATE OF DEATH Month November	Day 16 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1876	9. AGE (In years lost birthday) yrs 82	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Carroll County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME S. Howard Lockard			14. MOTHER'S MAIDEN NAME Mary V. Read			Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 111-11-1111		17. INFORMANT Howard H. Myerly Liberty St. Westminster, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage (Several times) (INTERVAL BETWEEN ONSET AND DEATH 44dx DUE TO cardio-renal vascular disease about 4 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility (c) none						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Westminster		20f. (City or town) Westminster (County) Maryland (\$State)
21. I certify that I attended the deceased from Nov. 17 , 1958, to Nov. 14 , 1958, that I last saw the deceased alive on Nov. 15 , 1958, and that death occurred at 8:45 A.M. from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>C. Levine Billingslea</i>	M.D.		ADDRESS (Street, city or town, state) 1 S. Center St. Westminster, Maryland		DATE SIGNED Nov. 17-58	
PHYSICIAN'S NAME (Type) C. Levine Billingslea M.D.						
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-58		22c. NAME OF CEMETERY OR CREMATORIUM Pleasant Grove		22d. LOCATION (City, town, or county) Sandyville, Maryland (\$State)
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Maryland		24a. REC'D BY REGISTRAR DATE NOV 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Drama

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12349

Item 8 FilmG236 12-11-28 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12349

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Carroll MARYLAND		Maryland Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
Rural Mt. Airy		Carroll	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
	Rural — Mt. Airy		
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Parrsville			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle W.	Last MYERS
4. DATE OF DEATH	Month November	Day 28	Year 1958
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-1896 1894
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Melvin Myers		14. MOTHER'S MAIDEN NAME Margaret Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 705-09-7320	17. INFORMANT Melvin Myers, Same	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) 443X DUE TO Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Hypertensive Cardiovascular Disease (c)		Several years	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 1953, to Nov 1958, that I last saw the deceased alive on November 26, 1958, and that death occurred at 10 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Nov 28, 1958	
ACTUAL SIGNATURE W.B. Culwell	M.D.	W.B. Culwell	
PHYSICIAN'S NAME (Type) W.B. Culwell	Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-1-1958	22c. NAME OF CEMETERY OR CREMATORIUM Simpsons Chapel	22d. LOCATION (City, town, or county) (State) Howard Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	24a. REC'D BY REGISTRAR DEC 1 '58 DATE
			24b. REGISTRAR'S SIGNATURE C. M. S. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

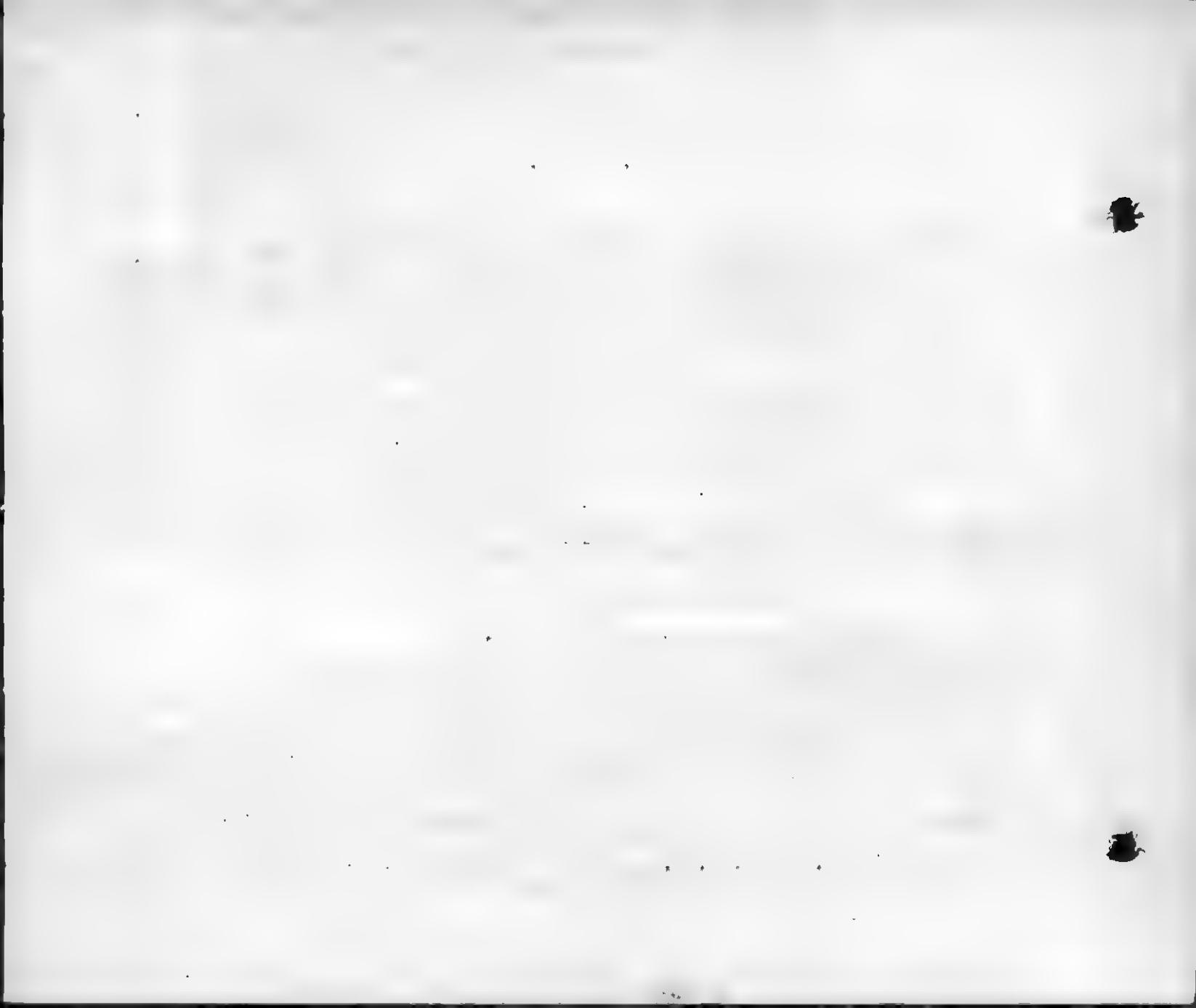
12350

CERTIFICATE OF DEATH

Reg. Dist. No.

12350

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)		c. LENGTH OF STAY IN 1b 57 yrs. 11 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Olga	Middle	Last Newman	4. DATE OF DEATH	Month November	Day 26,	Year 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown		9. AGE (in years last birthday) 84 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Unknown			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. 111-11-1111		17. INFORMANT Springfield State Hospital Record		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 40.1 DUE TO Acute Peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) Perforated Gastric Ulcer DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type.									
INTERVAL BETWEEN ONSET AND DEATH Days									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) White							
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hospital		20f. (City or town) Springfield	(County) Carroll	(State) Maryland	
21. I certify that I attended the deceased from 7 - 1 , 19 58, to November 26, 19 58, that I last saw the deceased alive on November 26, 19 58, and that death occurred at 7:20 A.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Rita S. Glahn									
DATE SIGNED 11/26/58									
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Rita S. Glahn, M. D.						Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-26-58		22b. DATE THEREOF 11-26-58		22c. NAME OF CEMETERY OR CREMATORIUM Springfield		22d. LOCATION (City, town, or county) Sykesville, Md.		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Rita S. Glahn		ADDRESS H. Height Sykesville, Md.		24a. REC'D BY REGISTRAR DATE DEC 2 '58		24b. REGISTRAR'S SIGNATURE John J. H. Height			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12351

CERTIFICATE OF DEATH

12351

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Sykesville (Rural)		c. LENGTH OF STAY IN 1b 2 y. 7 m. 4 d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Zone 14)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 5623 Tramore Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Rose	Middle Louisa	Last Nicklas	4. DATE OF DEATH November 17, 1958	Month November	Day 17	Year 1958
S. SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1870	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Germany		12 CITIZEN OF WHAT COUNTRY? 1st. papers USA	
13. FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Springfield State Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 443 X		1. Cardiac insufficiency				INTERVAL BETWEEN ONSET AND DEATH 1 day	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.		(b) 2. Hypertensive cardiovascular disease				years	
DUE TO		(c)					
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to November 17, 1958, that I last saw the deceased alive on November 17, 1958, and that death occurred at 4:00 P.M., from the causes and on the date stated above				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>Aguirre del Campo</i>		M.D. Springfield State Hospital					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-28-58		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town or county) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS 5305 Harford		24a. REC'D BY REGISTRAR NOV 19 '58		24b. REGISTRAR'S SIGNATURE Albert S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1-3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

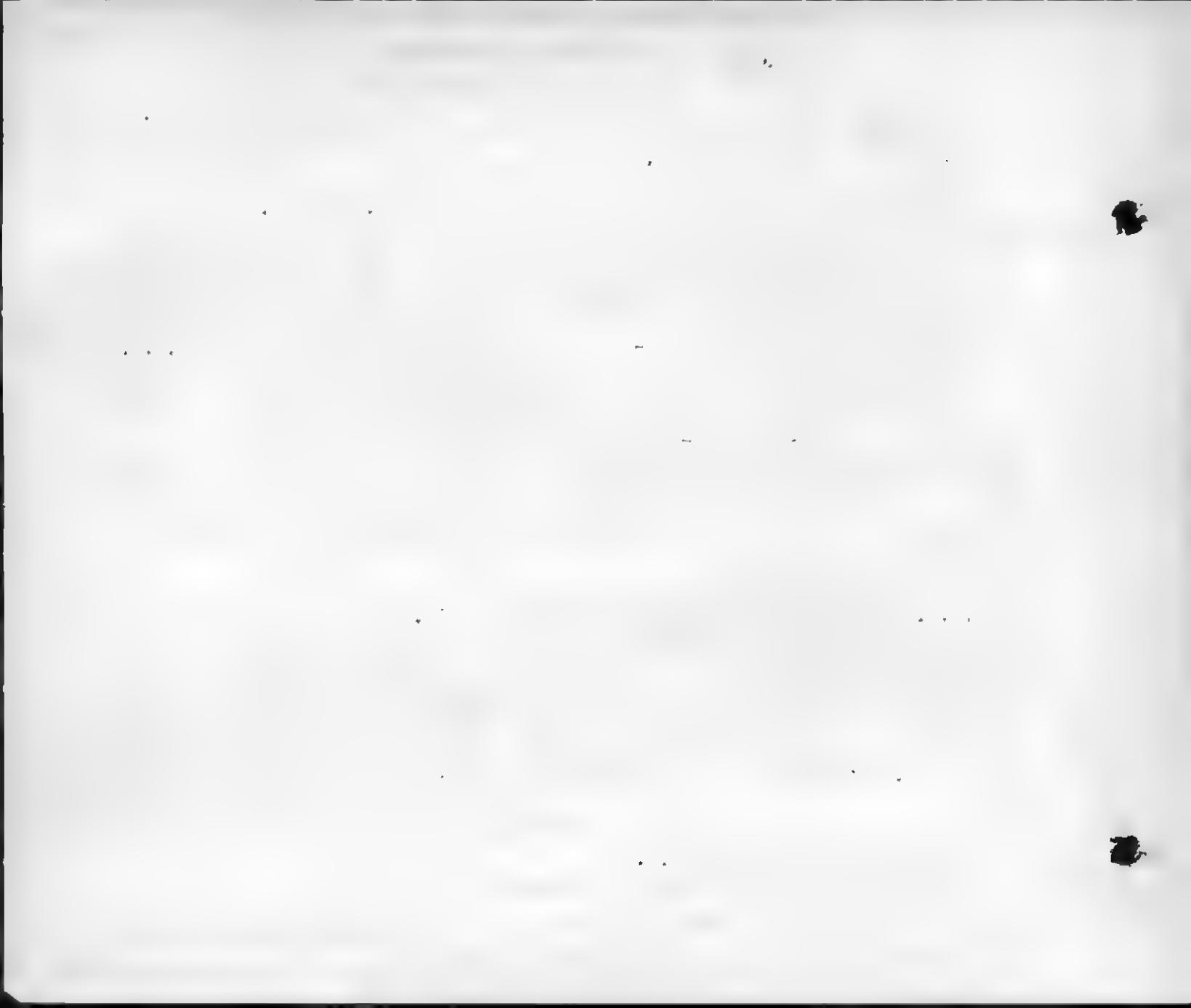
12352

CERTIFICATE OF DEATH

Reg. Dist. No.

12352

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Balt. City				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 16 lmo. 8days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2936 St. Paul St.				
3. NAME OF DECEASED (Type or print) Samuel Hunter Norman				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 2/8/1893		9. AGE (In years last birthday) yrs 85	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Norman				14. MOTHER'S MAIDEN NAME Ethel Suman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO 217-09-8967		17. INFORMANT		Address Springfield Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH Days 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) lying cause lost. (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.P.S. associated with cerebral arteriosclerosis. Generalized arteriosclerosis								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from October 3, 1958, to November 11, 1958, that I last saw the deceased alive on November 10, 1958, and that death occurred at 6:55A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/11/58								
ACTUAL SIGNATURE Agustin del Campo, M.D. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11/13/58		22b. DATE THEREOF 11/13/58		22c. NAME OF CEMETERY OR Crematory London Park		22d. LOCATION (City, town, or county) Balt. - 29 Yrd. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Howard Moules Jr. 108 W. North Ave.				ADDRESS		24a. REC'D BY REGISTRAR NOV 13 '58 DATE	24b. REGISTRAR'S SIGNATURE Oct. 13 '58	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												12353			
CERTIFICATE OF DEATH												Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				b. COUNTY Carroll							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flohrville				c. LENGTH OF STAY IN 1b 3 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural--Sykesville								d. STREET ADDRESS Flohrville							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) ERNEST				First M.	Middle PARKER	Lost	4. DATE OF DEATH NOV. 7, 1958	Month NOV.	Day 7	Year 1958					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 11-26-1870		9. AGE (In years lost birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 87		11. IF UNDER 24 HRS Hours 87			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter retired				10b. KIND OF BUSINESS OR INDUSTRY General				11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY U.S.			
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none				17. INFORMANT Mr. William Parker,				Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure, Atherosclerosis Generalized.												INTERVAL BETWEEN ONSET AND DEATH Oct 58			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), totaling the underlying cause (c).												 to			
(b) Atherosclerotic heart disease, Carcinoma												 7 Nov 58			
(c) 7 live.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
p. m.															
21. I certify that I attended the deceased from 1956 , 19, to 2 Nov , 1958, that I last saw the deceased alive on 7 Nov , 1958, and that death occurred at 4:50A.M. from the causes and on the date stated above												ADDRESS (Street, city or town, state) Asherville, Md.			
ACTUAL SIGNATURE Howard E. Hall												DATE SIGNED 7 Nov 58			
PHYSICIAN'S NAME (Type) HOWARD E. HALL															
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-10-1958		22c. NAME OF CEMETERY OR CREMATORIUM Fairmount				22d. LOCATION (City, town, or county) Libertytown, Md.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Md.				ADDRESS				24a. REC'D BY REGISTRAR DATE NOV 10 58				24b. REGISTRAR'S SIGNATURE John S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12354

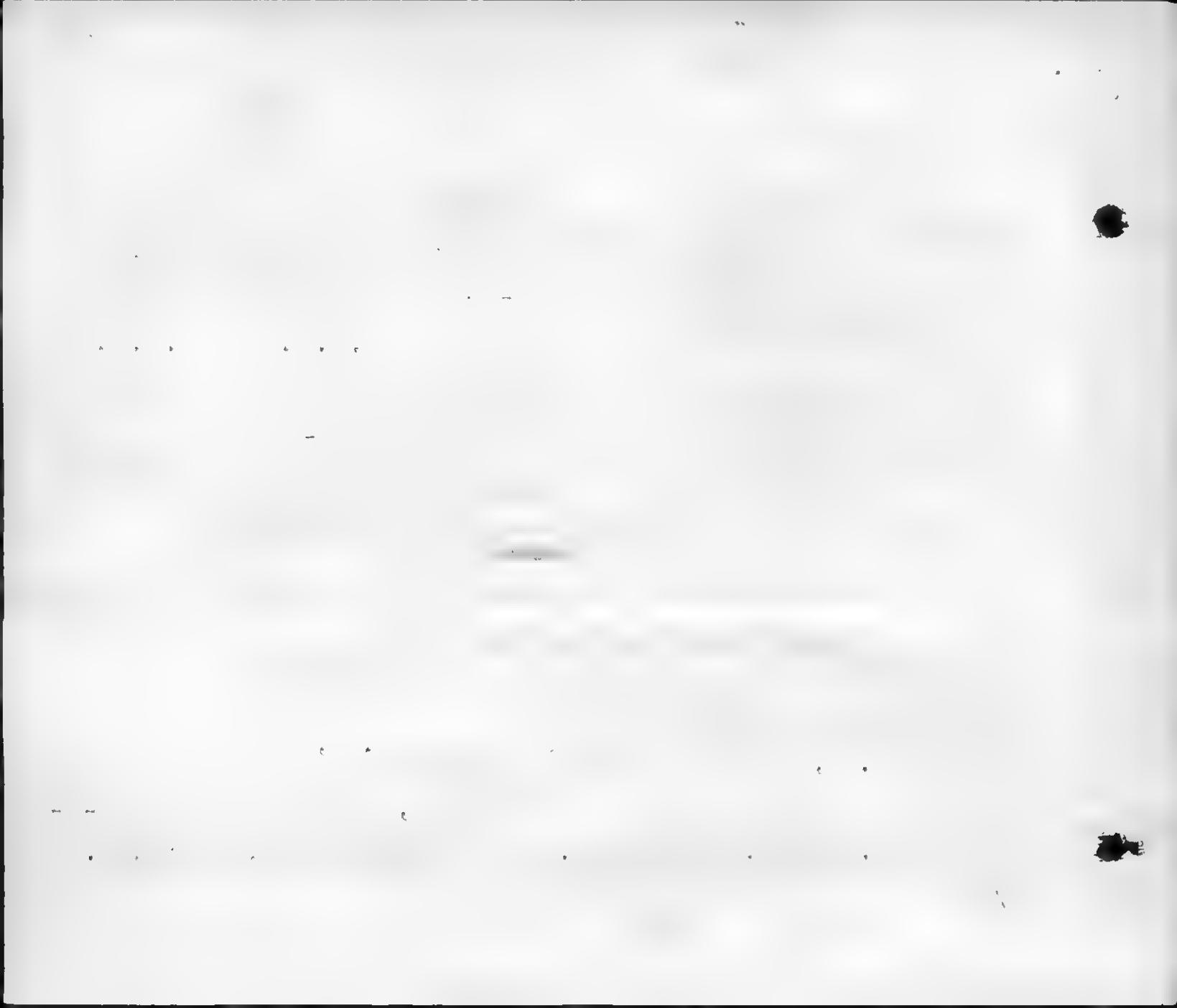
CERTIFICATE OF DEATH

Reg. Dist. No.

13587

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 493 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS Route #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First James	Middle Henry	Last Pittman	4. DATE OF DEATH November 30, 1958	Month November	Day 30	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-1911	9. AGE (in years less birthday) 47 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Rocky Mount, N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Julius Pittman				14. MOTHER'S MAIDEN NAME Laura Lilly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT James Henry Pittman - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Far advanced bilateral pulmonary tuberculosis and Diabetes Mellitus DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 25, 1957 to Nov. 30, 1958 , that I last saw the deceased alive on Nov. 30, 1958 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. M. Maculans</i> ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 11-30-58							
PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 7-1958		22c. NAME OF CEMETERY OR CREMATORIUM CHRIST, M.E.		22d. LOCATION (City, town, or county) Pocomoke, Worcester, MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles A. Ward, Main Street, M.L. #235</i>		ADDRESS <i>Main Street, M.L. #235</i>		24a. REC'D BY REGISTRAR DEC 9 58		24b. REGISTRAR'S SIGNATURE <i>Edgar S. Maculans</i>	

TO HOSPITAL OR ATTENDANT: The law requires that the death certificate be submitted within 24 hours after death. Page 3 should be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12355

CERTIFICATE OF DEATH

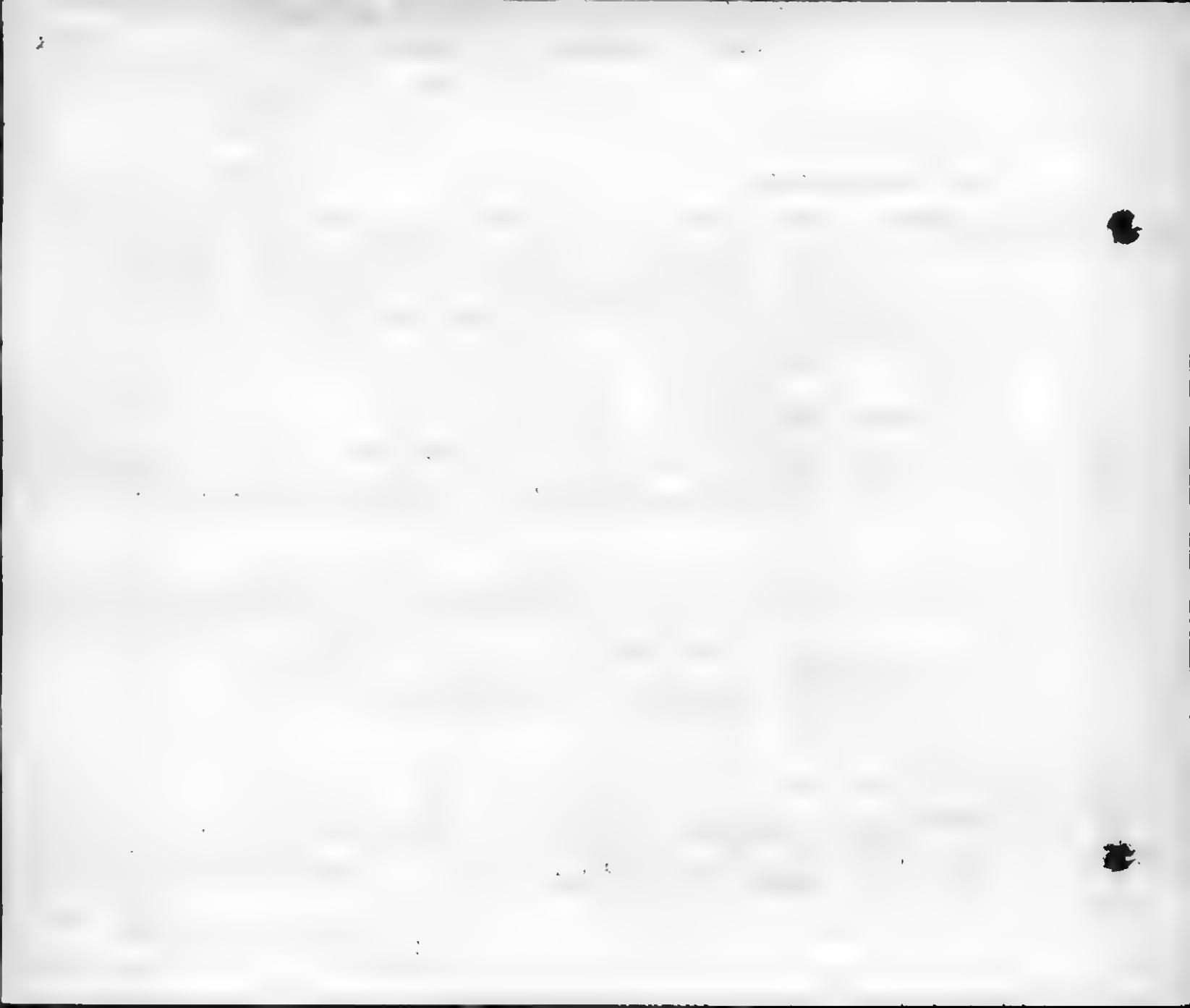
Reg. Dist. No.

12354

1. PLACE OF DEATH a. COUNTY <i>Carroll Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Carroll</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster</i>		c. LENGTH OF STAY IN 16 <i>75 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Royal, Westminster</i>		d. STREET ADDRESS <i>Pleasant Valley</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pleasant Valley</i>				d. STREET ADDRESS <i>Pleasant Valley</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>MILTON JACOB POWELL</i>		First	Middle	Last	4. DATE OF DEATH <i>NOV. 20 1958</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 9, 1883</i>	9. AGE (In years last birthday) <i>75 yrs</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired - defunct work shop yard</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pleasant Valley Carroll Md. U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Pleasant Valley Carroll Md. U.S.A.</i>		
13. FATHER'S NAME <i>Mark Powell</i>		14. MOTHER'S MAIDEN NAME <i>Martha Myers</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>218-10-2356</i>		17. INFORMANT <i>Mrs Martha C Powell, Westminster</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c)				Cardio-Nascular-Renal disease yrs.		INTERVAL BETWEEN ONSET AND DEATH		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Jan 1, 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>15 Kinner Ave</i>		20f. (City or town) <i>Westminster</i>		(County) (State)
21. I certify that I attended the deceased from <i>Jan 1, 1958</i> to <i>Nov 26 1958</i> that I last saw the deceased alive on <i>Nov 26 1958</i> , and that death occurred at <i>11:50 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>15 Kinner Ave</i>		
ACTUAL SIGNATURE <i>DR. F. REESE WILKENS</i>		PHYSICIAN'S NAME (Type) <i>DR. F. REESE WILKENS</i>				DATE SIGNED <i>Nov 16 1958</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Rural</i>		22b. DATE THEREOF <i>Nov. 24 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Pleasant Valley Cemetery</i>		22d. LOCATION (City, town, or county) <i>Royal, Westminster, Md.</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>X. S. Myers, Jr.</i>		ADDRESS <i>Westminster Md.</i>		24a. REC'D BY REGISTRAR <i>John S. Hayes</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Hayes</i>		
				DATE <i>NOV 24 1958</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1-3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12356

CERTIFICATE OF DEATH

Reg. Dist. No.

12355

1. PLACE OF DEATH a. COUNTY Carroll			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland			b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)			c. LENGTH OF STAY IN 1b 7 mo. 8 das.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Woodbine			d. STREET ADDRESS R.F.D. #1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Agnes			First	Middle	Last	4. DATE OF DEATH November 26,	Month	Day	Year	1958	
5. SEX Female			6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 2, 1889	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Mullen			14. MOTHER'S MAIDEN NAME Ellen Graham								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address Springfield State Hospital, Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Lobar Pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 491.0 (b) 2. Multiple decubital ulcers DUE TO (c) 3. Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 4 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Manic depressive reaction, depressed type. Incipient cerebral arterio- sclerosis. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> p. m. 19 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 1, 1957, to November 26, 1958, that I last saw the deceased alive on November 26, 1958, and that death occurred at 11:10 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Rita S. Glahn			M.D.			ADDRESS (Street, city or town, state) Springfield State Hospital			DATE SIGNED 11/26/58		
PHYSICIAN'S NAME (Type) Rita S. Glahn, M. D.			22a. NAME OF CEMETERY OR CREMATORIUM St. J. & M. Cemetery			22d. LOCATION (City, town, or county) Baltimore			(State)		
22b. BURIAL, CREMATION, REMOVAL (Specify) 12-1-58			22c. DATE THEREOF 12-1-58			24a. REC'D BY REGISTRAR Date DEC 2 '58			24b. REGISTRAR'S SIGNATURE Rita S. Glahn		
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. Newell			ADDRESS Sykesville 8 Md.								
VS A15(4) 15M 9/55											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 11 G 76 12-4-8 et

12307

CERTIFICATE OF DEATH

12356

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL CO.		1b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		1c. LENGTH OF STAY IN 1b 9 MO.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY CARROLL	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, WESTMINSTER			
						d. STREET ADDRESS WARFIELDSBORG		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First CARRIE	Middle ESTELLE	Last RANOULL	4. DATE OF DEATH NOV. 27 1958	Month	Day	Year	
S. SEX F.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 10, 1879		9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House - WIFE		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) CARROLL CO. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME THOMAS S. JONES		14. MOTHER'S MAIDEN NAME ANGELINE SELLERS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO -		17. INFORMANT ELLIS C. RANOULL, MANCHESTER MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Renal Disease INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause lost. DUE TO General (b) Arteriosclerosis & Hypertension DUE TO several (c) Cerebral Hemorrhage DUE TO 4 yrs 1956									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that I attended the deceased from Nov , 19 58 to Nov 27, 1958 , that I last saw the deceased alive on Nov 24, 1958 , and that death occurred at 6 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE W. Glenn Speicher, M.D.		ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 11/28/58							
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/30/58		22c. NAME OF CEMETERY OR CREMATORIUM MEADOW BRANCH RURAL, WESTMINSTER		22d. LOCATION (City, town, or county) WESTMINSTER		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr., Westminster, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

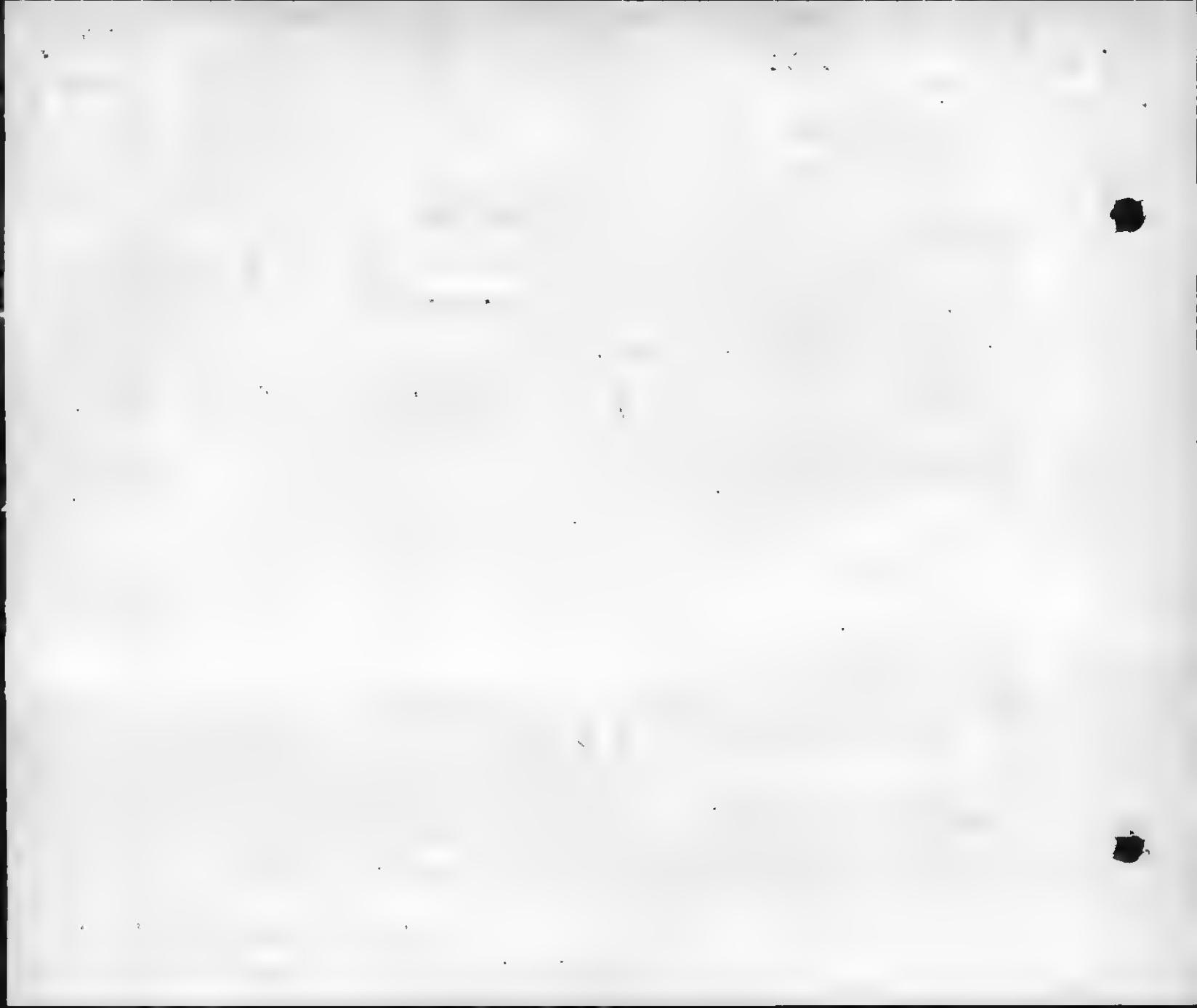


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												Reg. Dist. No. 12357	
12357 Item 2 fil. 11-20-58 et CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				a. STATE Maryland b. COUNTY Montgomery									
c. LENGTH OF STAY IN lb 2 mos 25 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Collel Hill Silver Spring									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State				d. STREET ADDRESS 571 University Blvd., MD'S RESIDENCE ON A FARMS Green's MARYLAND 1958 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First William	Middle Arnold	Last Ray	4. DATE OF DEATH	Month 11	Day 9	Year 1958					
5. SEX Male		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1887		9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) former Painter		11. KIND OF BUSINESS OR INDUSTRY - Retired.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Thomas Ray		14. MOTHER'S MAIDEN NAME Susan Schaeffer											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 214-03-9588		17. INFORMANT At hospital records		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH years	
4.1.2		Atherosclerotic Heart Disease Generalized Atherosclerosis										years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) C.B.S. on, with cerebral atherosclerosis with psychotic reaction											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 80/415		(County)		(State)			
21. I certify that I attended the deceased from 11/9/58, to 11/9/58, that I last saw the deceased alive on 11/9/58, and that death occurred at 145 P.M. from the causes and on the date stated above.													
ACTUAL SIGNATURE Gertrude M. Gross, M.D.		ADDRESS (Street, city or town, state) 11-9-58 DATE SIGNED											
PHYSICIAN'S NAME (Type) Gertrude M. Gross		Springfield State Hosp. Sykesville, Md.											
22a. BURIAL, CREMATION, BURIAL		22b. DATE THEREOF 11-12-58		22c. NAME OF CEMETERY OR CREMATORIUM Colesville Church Cem.		22d. LOCATION (City, town, or county) Montgomery County, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE NOV 12 '58		24b. REGISTRAR'S SIGNATURE C. L. Kline							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12308

CERTIFICATE OF DEATH

Reg. Dist. No.

12358

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 which is to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Carroll</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. LENGTH OF STAY IN 1b <i>40 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		d. STREET ADDRESS <i>Klinger Apts 6 Main St.</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Klinger Apts 6 Main St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <i>HARRY EDWARD REESE SR.</i>		First <i>H</i>	Middle <i>E</i>	Last <i>REESE</i>	4. DATE OF DEATH <i>Nov. 15 1958</i>	Month <i>Nov.</i>	Day <i>15</i>	Year <i>1958</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 26, 1899</i>		9. AGE (In years last birthday) <i>59 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clothes Laundry - Laundry</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carroll Co. Md.</i>		11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Edward Reese</i>		14. MOTHER'S MAIDEN NAME <i>Sadie Little</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Harry E. Reese, Jr. Westminster, Md.</i>		Address <i>Westmister, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>(b)</i>		REASON <i>Acute Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hour</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Chronic (arterio-Sclerosis -</i>		DUE TO <i>(c)</i>				15 years.				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>79 W. Main St.</i>		(County) <i>Westmister, Md.</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>11/15 1958</i> to <i>11/15 1958</i> , that I last saw the deceased alive on <i>11/15 1958</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>79 W. Main St. Westminster, Md.</i>				DATE SIGNED <i>11/15/58</i>
ACTUAL SIGNATURE <i>Slusher Bare</i>		PHYSICIAN'S NAME (Type) <i>SLUTHER BARE</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 18, 1958</i>		22c. NAME OF CEMETERY OR CRYPTATORY <i>Madison Branch</i>		22d. LOCATION (City, town, or county) <i>Westmister, Md.</i>		(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers Jr. Westminster, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>NOV 18 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12358

CERTIFICATE OF DEATH

Reg. Dist. No.

12359

1. PLACE OF DEATH

a. COUNTY

Overall

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

City of Halethorpe

c. LENGTH OF STAY IN 1b

Fife

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)

a. STATE

Md.

b. COUNTY

Halethorpe

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

City of Halethorpe

d. STREET ADDRESS

Central Ave.

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF DECEASED

(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Aug. 16, 1883

9. AGE (In years
last birthday)

76 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS

Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

livestock dealer

10b. KIND OF BUSINESS OR INDUSTRY

Cattle

10c. BIRTHPLACE (State or foreign country)

Md.

11. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Richardville R. Richardson

14. MOTHER'S MOTHER'S NAME

Elizabeth Gray

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

-

17. INFORMANT

Mrs. Alice Richardson

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1440

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

ARTERIOSCLEROTIC HEART DISEASE

INTERVAL BETWEEN
ONSET AND DEATH

10 yrs.

HYPERTENSIVE CARDIOVASCULAR DISEASE

20 yrs.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month Day Year
Hour a.m. 19 p.m.20d. INJURY OCCURRED
White Not white
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 1935, 19, to 22 November, 1958, that I last saw the deceased alive on 21 November, 1958, and that death occurred at 12:40 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

M.D. Liberty Road at Eldersburg

11.22.58

PHYSICIAN'S
NAME (Type)

Wm. H. Lawson, Jr., M.D.

Sykesville P.O., Maryland

22a. BURIAL, CREMATION,
REMOVAL (Specify)

11-24-58

22b. DATE THEREOF

11-24-58

22c. NAME OF CEMETERY OR Crematory

Chesapeake

22d. LOCATION (City, town, or county)

Sykesville, Md.

(State)

23. FUNERAL-DIRECTOR'S SIGNATURE

Foster H. Haight

ADDRESS

Sykesville, Md.

24a. REC'D BY REGISTRAR

Oct. 22, 1958

24b. REGISTRAR'S SIGNATURE

Audrey E. Kline



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12359 CERTIFICATE OF DEATH

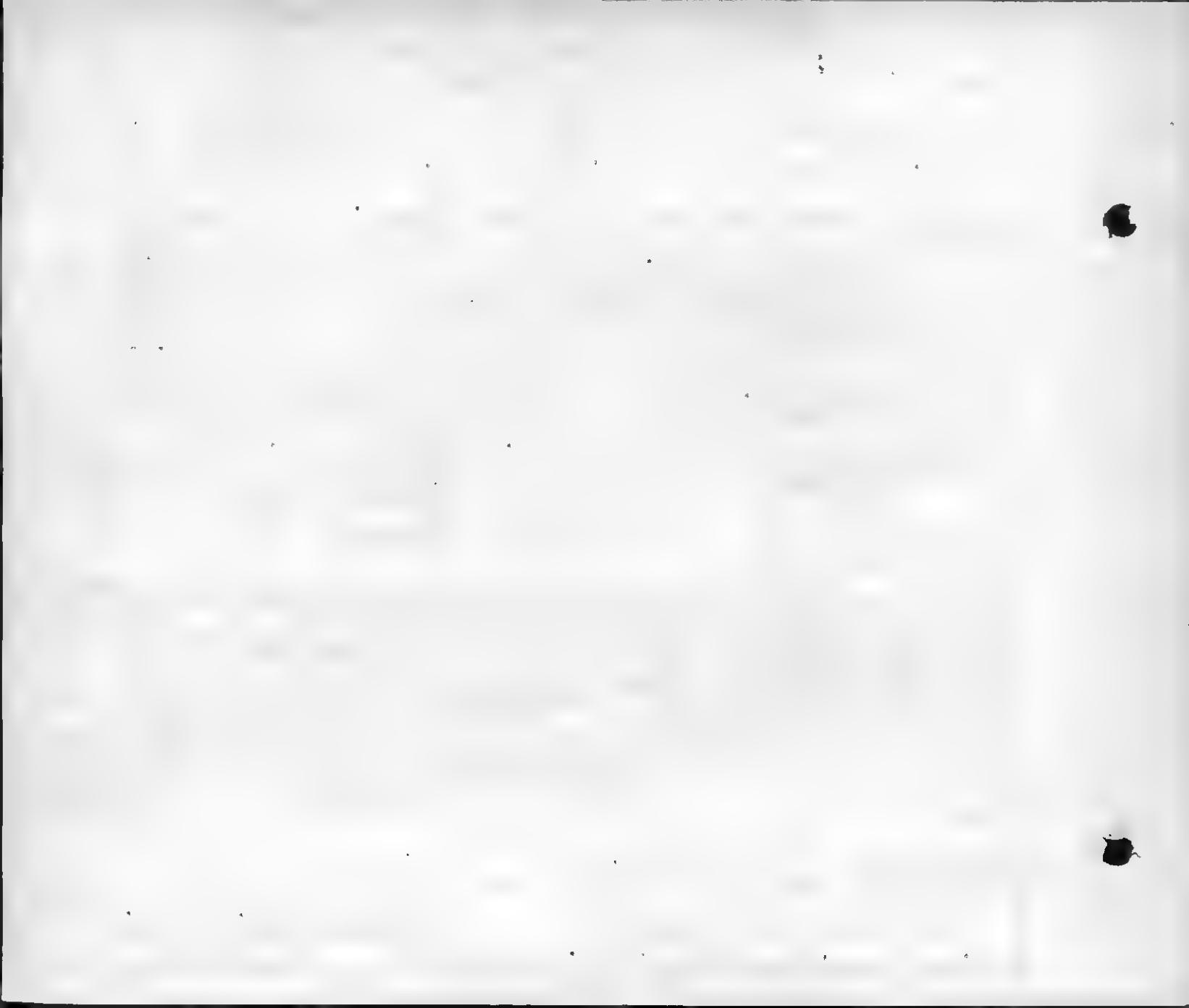
Reg. Dist. No.

12360

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. LENGTH OF STAY IN 1b 52 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy	
f. STREET ADDRESS Main St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GRACE		First M.	Middle ROUTZAHN
4. DATE OF DEATH NOV. 9, 1958	Month Day Year		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-1879
9. AGE (in years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles E. Wilcox		14. MOTHER'S MAIDEN NAME Mary Elizabeth Quincy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Margeret Miller, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized arteriosclerosis		years	
(c) Hypertension		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral-vascular accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 1b.] none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 1956, to Nov. 9, 1958, that I last saw the deceased alive on Nov. 9, 1958, and that death occurred at 4:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Main Street DATE SIGNED 11/10/58			
ACTUAL SIGNATURE G. Meadors, M.D.		PHYSICIAN'S NAME (Type) Gilcin F. Meadors, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-12-1958	
22c. NAME OF CEMETERY OR CREMATORIUM Reformed		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Md.		24a. REC'D BY REGISTRAR DATE NOV 13 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12360

Reg. Dist. No.

12361

FOR STATE
HEALTH DEPT.

To EXECUTIVE DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary please execute it in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)	
<i>Burwell</i>		a. STATE <i>Maryland</i> b. COUNTY <i>Burwell</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester (Rural)</i>		c. LENGTH OF STAY IN lb <i>None</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Syndersbury Rural</i>	
e. STREET ADDRESS		d. IS RESP'D ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
II NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Nov Day 16 Year 1958	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb 8-1909</i>	
WIDOWED <input type="checkbox"/>		9. AGE (in years last birthday) 49 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Caretaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Sandwick</i>		14. MOTHER'S MAIDEN NAME <i>Maggie Ely</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>215-36-8235</i> 17. INFORMANT <i>Jesse Sandwick, Manchester Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>825X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Stole the underlying cause test.</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>none</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <i>Automobile accident</i>	
20c. TIME OF INJURY Month, Day Year Hour o. m. <i>5 - pm. 11-16 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Route 30	
20e. PLACE OF INJURY (Home, farm, doctor's office, etc.)		20f. (City or town) (County) (State) <i>Manchester Anne Arundel</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James J. Marsh</i>		DATE SIGNED <i>11/16/58</i>	
EXAMINER'S NAME (Type) <i>JAMES T MARSH</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-18-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Manchester</i>		22d. LOCATION (City, town, or county) <i>Burwell Co Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edie Ellington, Hampstead Md</i>		24a. REC'D BY REGISTRAR <i>NOV 18 '58</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Caroline L. Knott</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/54

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12361

CERTIFICATE OF DEATH

Reg. Dist. No.

12362

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 49y.6m.17d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS -----	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MINNIE	Middle -----	Last SCHOEN	4. DATE OF DEATH	Month November	Day 29	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years lost birthday) 77 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CIT.ZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Schoen				14. MOTHER'S MAIDEN NAME -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4471X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, hebephrenic type						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) (State)
21. I certify that I attended the deceased from October 20, 1954, to November 29, 1958, that I last saw the deceased alive on November 29, 1958, and that death occurred at 3:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL <u>Edmund Lusthaus</u> M.D. Springfield State Hospital							
PHYSICIAN'S NAME (Type)		Edmund Lusthaus, M. D.		Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF -----		22c. NAME OF CEMETERY OR CREMATORIUM St. of Maryland, Sykesville		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. Newell, Sykesville, Md.		ADDRESS -----		24a. REC'D BY REGISTRAR DATE DEC 5 '58		24b. REGISTRAR'S SIGNATURE C. Ruth S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12362

CERTIFICATE OF DEATH

Reg. Dist. No.

12363

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 37 yrs. 1 mo. 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		d. STREET ADDRESS None	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION Springfield State Hospital.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Prince	Middle Albert	Last Shroud	4. DATE OF DEATH	Month November	Day 8	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1885	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Tasker				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO -		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the esophagus							
INTERVAL BETWEEN ONSET AND DEATH Unknown							
150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mental Deficiency							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 to November 8, 1958 , that I last saw the deceased alive on November 8, 1958 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Springfield Hospital							
ACTUAL SIGNATURE Agustin del Campo, M.D.							
DATE SIGNED 11/9/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-10-58		22b. DATE THEREOF 11-10-58		22c. NAME OF CEMETERY OR CREMATORIUM 203 Maryland Road		22d. LOCATION (City, town, or county) Baltimore, Md.	
(State)							
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. Nevell, Sykesville, Md.							
ADDRESS 24a. REC'D BY REGISTRAR DATE NOV 13 '58							
24b. REGISTRAR'S SIGNATURE C. Smith & Son							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12364

12363

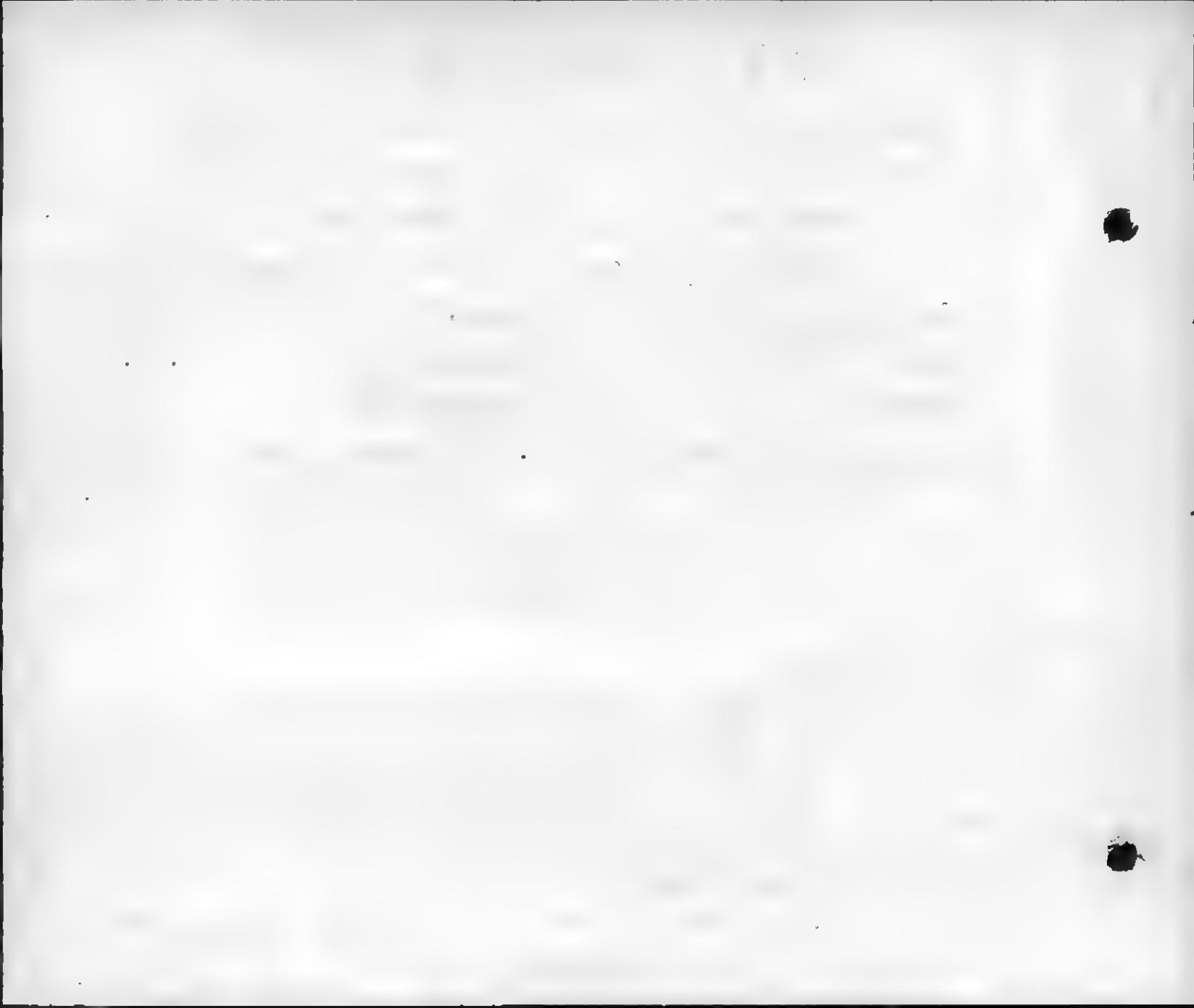
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		d. STREET ADDRESS George Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION George Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William Francis Simpson		First	Middle	Last	4. DATE OF DEATH November 22 1958	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 9, 1878	9. AGE (in years from birth) 80 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME James Simpson		14. MOTHER'S MAIDEN NAME Susan Miller						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Mellie Simpson		Address Taneytpwn, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 mos				
Cerebral Arteriosclerosis		2 years						
Generalized Arteriosclerosis		20 yrs						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19 Nov. 1958								
21. I certify that I attended the deceased from Dept. , 19 58 , to 11/24/58 , that I last saw the deceased alive on 11/21 1958 , and that death occurred at 2 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE R. S. McVaugh		ADDRESS (Street, city or town, state) 49 Frederick St. DATE SIGNED 11/24/58						
PHYSICIAN'S NAME (Type) R. S. McVaugh		Taneytown, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 24, 1958		22c. NAME OF CEMETERY OR CREMATORIUM United Church of Christ Cemetery, Taneytown, Maryland		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Mirwyn C. Fuss		ADDRESS C. O. Fuss & Son		24a. REC'D BY REGISTRAR NOV 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		
		Taneytown, Maryland						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 so as to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12364

CERTIFICATE OF DEATH

Reg. Dist. No.

12365

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 16 <i>4 mo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>+8 W Preston Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Meadow View Convalescent Home</i>		d. STREET ADDRESS <i>18 W Preston St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>IDA</i>	Middle <i>Priscilla</i>	Last <i>Thomas</i>	4. DATE OF DEATH <i>Nov</i>	Month <i>/</i>	Day <i>1</i>	Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>ld.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 1 1874</i>	9. AGE (In years last birthday) <i>84 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i></i>	Days <i></i>	Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own business</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John P.</i>		14. MOTHER'S MAIDEN NAME <i>Iley</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no—known) <i>No</i>		16. SOCIAL SECURITY NO <i>216-734-7109</i>		17. INFORMANT <i>Mrs Ralph Royer</i>		Address <i>Washington Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>a.s.c.v. disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 days - years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>491X</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>105 E. Main St</i>		20f. (City or town) (County) (State) <i>Washington</i>	
21. I certify that I attended the deceased from <i>July 11, 1958</i> , to <i>Nov 1, 1958</i> , that I last saw the deceased alive on <i>Oct 31, 1958</i> , and that death occurred at <i>8:55 A.M.</i> from the causes and on the date stated above ACTUAL SIGNATURE <i>James T. Marsh</i> M.D. ADDRESS (Street, city or town, state) <i>105 E. Main St Washington</i> DATE SIGNED <i>11/1/58</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11-4-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Highland Cemetery</i>		22d. LOCATION (City, town, or county) Street, Md <i>Washington</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 5 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



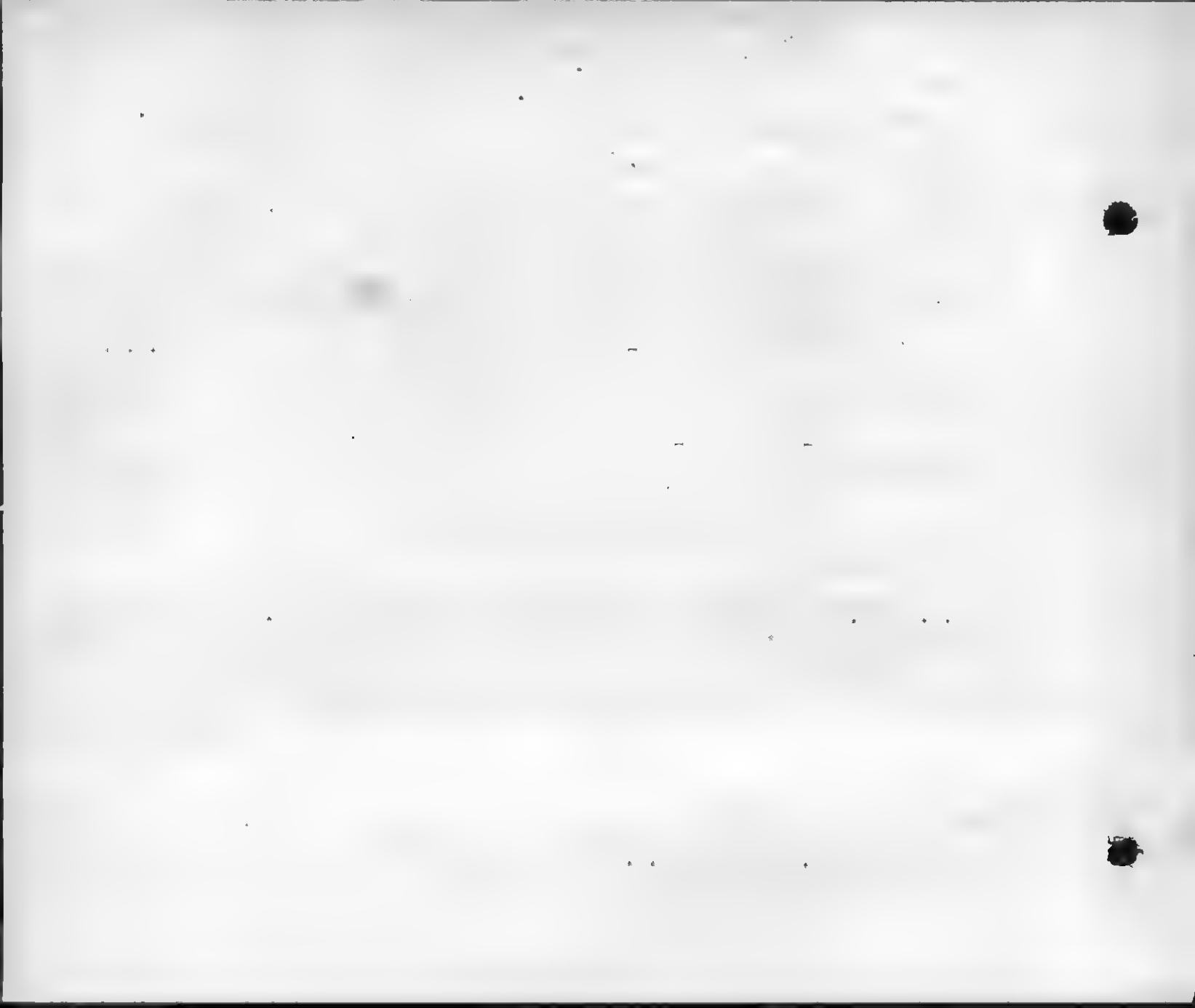
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12365 Items 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12366

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		b. COUNTY Balto. City	
c. LENGTH OF STAY IN 1b 3mos. 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3706 Nortonia Road, Zone 16	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Lee	Last Timberlake
4. DATE OF DEATH November 15, 1958	Month Year Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 6, 1880
9. AGE (In years lost <input type="checkbox"/> birthday)	10. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Theodore Harrell	14. MOTHER'S MAIDEN NAME Nancy Graves		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown) No	16. SOCIAL SECURITY NO - - -	17. INFORMANT Springfield Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH Years
DUE TO 45.0.0			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis			Years
DUE TO (c)			
C.B.S. assoc. with senile brain disease with psychotic reaction. Bronchopneumonia.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 28, 1958 , to November 15, 1958 , that I last saw the deceased alive on November 15, 1958 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irene L. Hitchman, M.D. 11/15/58			
ACTUAL SIGNATURE <i>Irene L. Hitchman</i>		PHYSICIAN'S NAME (Type) Irene L. Hitchman, M.D. Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF 11-17-58	22c. NAME OF CEMETERY OR CREMATORIUM HILL CREST	22d. LOCATION (City, town, or county) LOUISA. VA. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Walter Gabowski: 100 Randolph Ave.	ADDRESS	24a. REC'D BY REGISTRAR NOV 18 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12366

CERTIFICATE OF DEATH

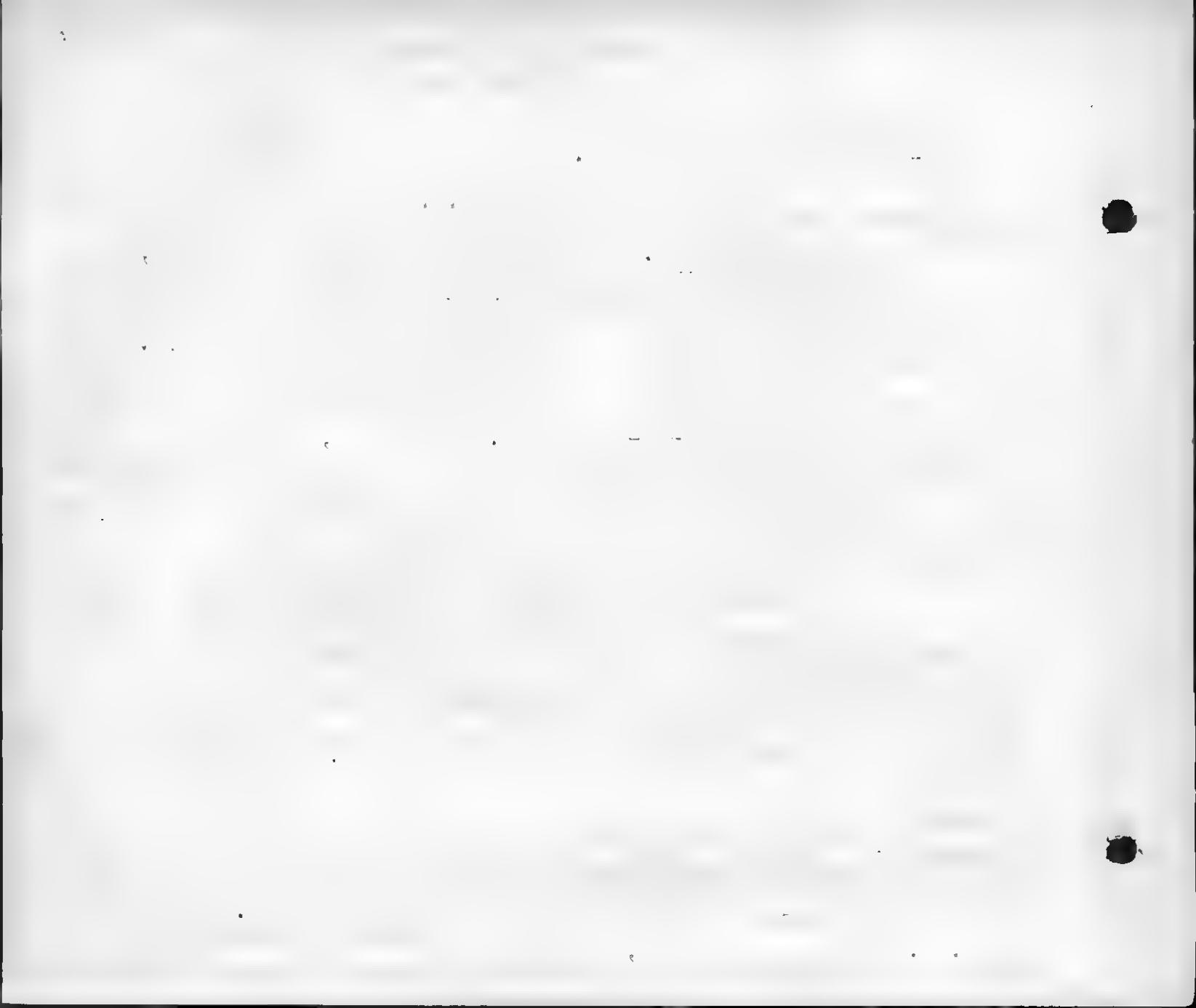
12367

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Westminster		c. LENGTH OF STAY IN 1b 37 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR		First F.	Middle WILL
4. DATE OF DEATH Month NOV.	Day 27,	Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1886
9. AGE (In years lost/birthday) yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY owner	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME William Will	
14. MOTHER'S MAIDEN NAME Fredericka Hintzman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 219-36-0185		17. INFORMANT Mrs. Renie Will, same	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4. <i>coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Aterio sclerosis General &</i> DUE TO (c) <i>myocardial degeneration</i>		INTERVAL BETWEEN ONSET AND DEATH 1 day several yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 3, 1958</u> to <u>Nov 27, 1958</u> that I last saw the deceased alive on <u>Nov 26, 1958</u> , and that death occurred at <u>12:05 P.M.</u> from the causes and on the date stated above.		22. ADDRESS (Street, city, town, state) <i>Glenn Speicher, M.D. Westminster Md</i>	
ACTUAL SIGNATURE <i>Glenn Speicher</i>		DATE SIGNED <u>11/28/58</u>	
PHYSICIAN'S NAME (Type) W. GLENN SPEICHER		22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial	
22b. DATE THEREOF 11-30-1958		22c. NAME OF CEMETERY OR CREMATORIUM Ebenezer	
22d. LOCATION (City, town, or county) Carroll Co., Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. L. Waltz,		24a. REC'D BY REGISTRAR DATE DEC 1 '58	24b. REGISTRAR'S SIGNATURE <i>John S. Haas</i>
ADDRESS Winfield, Maryland			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

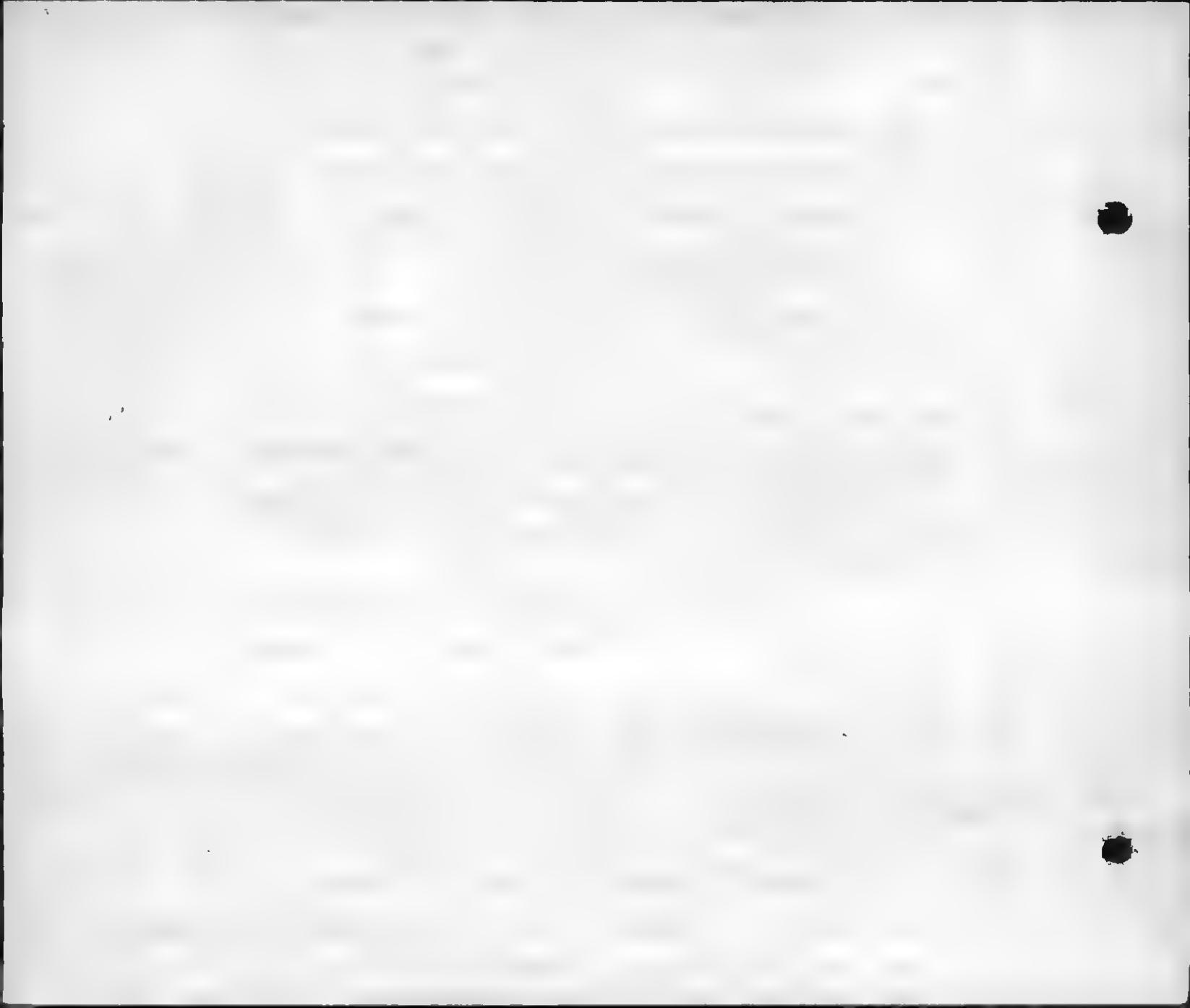
12367

CERTIFICATE OF DEATH

12368

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Carroll Co</i>				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Burke, Maryland</i>		50 yrs		<i>Burke, Md., County, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Hickman's Md., Petty</i>		<i>Hickman's Hickman's Rd #4</i>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
<i>KATHERINE AUGUSTA WITTE</i>					Month Day Year
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.
<i>f.</i>	<i>White</i>	<i>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>Jan. 31, 1880</i>	<i>78 yrs.</i>	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Housewife</i>		<i>-</i>		<i>Baltimore, Md.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<i>? JORDAN</i>		<i>? STRUIT</i>		<i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or dates of service)				<i>Mrs. Emma K. Jordan, Hickman's Rd #4</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>- 4 days</i>	
DUE TO		<i>Antemortem</i>		<i>5 yrs</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		(b)		<i>5 yrs</i>	
		DUE TO		<i>Hyper tension</i>	
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I attended the deceased from <i>April 16, 1957</i> , to <i>Nov 14, 1958</i> , that I last saw the deceased alive on <i>Nov 13, 1958</i> , and that death occurred at <i>1:30 A.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE				ADDRESS (Street, city or town, state) <i>M.D. Manchester, Md.</i> DATE SIGNED <i>11-14-58</i>	
PHYSICIAN'S NAME (Type)		<i>W.H. Foard M.D.</i>		<i>Manchester, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL	
<i>Burial Nov. 16, 1958</i>		<i>Sister's Cemetery</i>		<i>Westminister, Md., Rd #4</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE	
<i>E. Myers, Jr., Hickman's, Md.</i>				<i>Nov 17 '58</i>	
VS AIS (4) 15M 9/55				24b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12368

CERTIFICATE OF DEATH

Reg. Dist. No.

12369
74

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton, Maryland		c. LENGTH OF STAY IN 1b 117 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Alice	Middle 	Last Woodland	4. DATE OF DEATH November	Month 18	Day 19	Year 58
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH ? ? 1887	8. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS Hours 	Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oakville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Gray				14. MOTHER'S MAIDEN NAME Rebecca Smothers				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Bernice Wood - 1627 N. Bentallou Street		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident						INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriosclerosis and heart failure								
DUE TO (c) Far advanced pulmonary tuberculosis.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)
								(State)
21. I certify that I attended the deceased from July 24, 1958 , to Nov. 18, 1958 , that I last saw the deceased alive on Nov. 18, 1958 , and that death occurred at 11:20A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED 11-18-58
ACTUAL SIGNATURE <i>E. M. Maculans</i>		M.D.		Henryton, Maryland				
PHYSICIAN'S NAME (Type) E. M. Maculans, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/22/58		22c. NAME OF CEMETERY OR CREMATORIUM Galliee Cemetery		22d. LOCATION (City, town, or county) Oakville, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rodinson Funeral Home Leonhardt</i>		ADDRESS <i>Md.</i>		24a. REC'D BY REGISTRAR DAHOV 2 4 '58		24b. REGISTRAR'S SIGNATURE <i>in her hand</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed with page 3. It should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



15

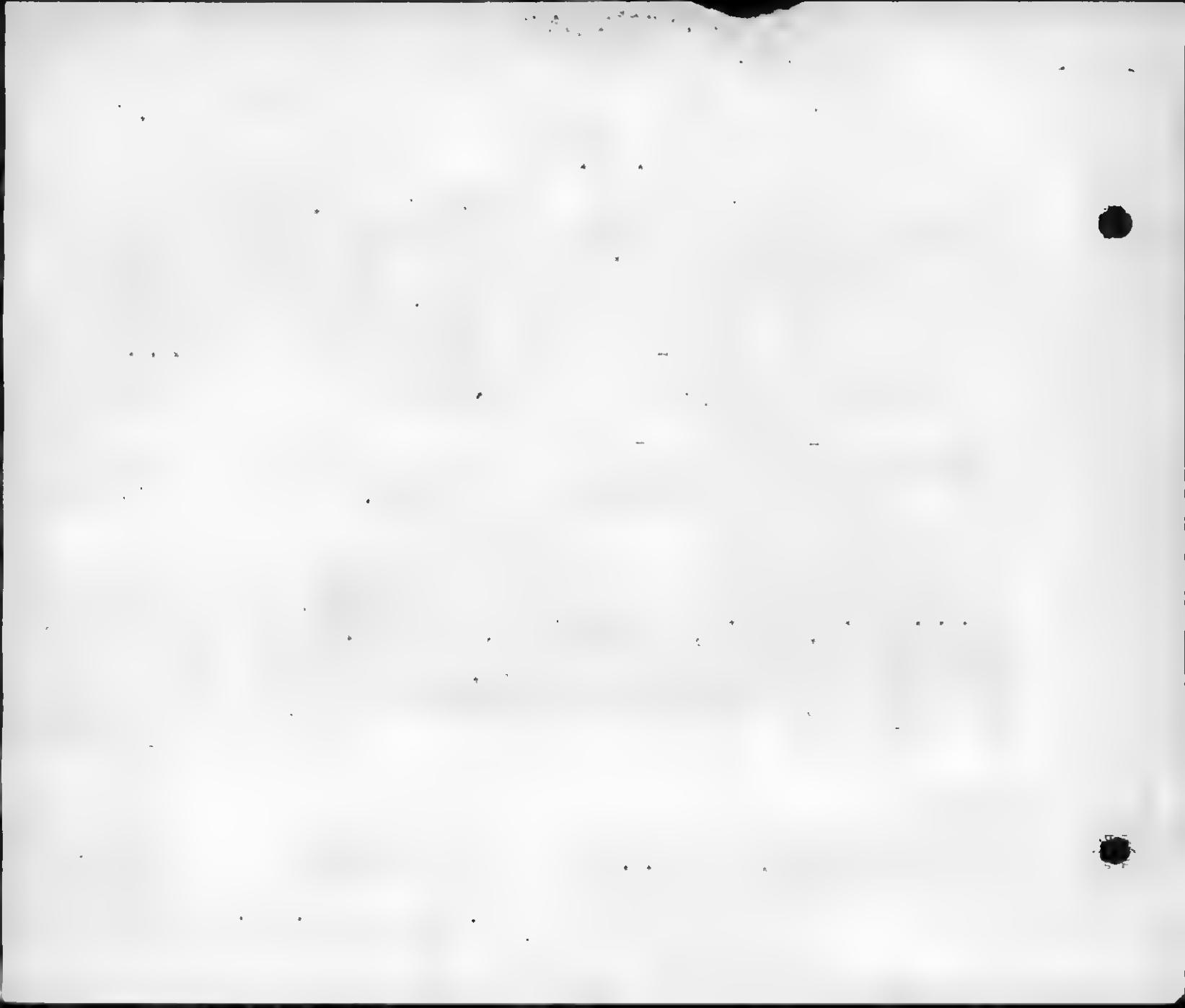
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12369 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12370

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE [Where deceased lived <input type="checkbox"/> in instit.] on Residence before admission] a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb Byrs. 6mos. 12days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 2924 Miles Ave.	
e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary		First M	Middle E.
4. DATE OF DEATH November 14, 1958		Last Worick	Month November
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 1876- Feb. 10,		9. AGE (In years less birthday) 82 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John L. Booze		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (You, no, or unknown) No		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Arteriosclerotic heart disease.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. DUE TO Conditions, if any, which gave rise to immediate cause (b) - - - IMMEDIATE CAUSE (a), stating the underlying cause last. 902-7 DUE TO (c) - - -			
INTERVAL BETWEEN ONSET AND DEATH Years			
C. P.A.T. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition with senile brain disease. Fracture, intertrochanteric, right femur.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Patient fell out of bed.	
20c. TIME OF INJURY Month, Day, Year 8:00 a.m. 11/5/58		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> place of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Sykesville Carroll Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James T. Marsh</i>		DATE SIGNED 11/15/58	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify) Burial 11/17/58		22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.	
22d. LOCATION (City, town, or county) Balto. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Ticknor & Sons - Balt. 17th</i>		24a. REC'D BY REGISTRAR NOV 17 1958	
		24b. REGISTRAR'S SIGNATURE <i>Arthur & Anna</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12370

CERTIFICATE OF DEATH

Reg. Dist. No.

12371

1. PLACE OF DEATH a. COUNTY Carroll		Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY -					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville		c. LENGTH OF STAY IN lb 1 yr-3mo.15days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City, Maryland		d. STREET ADDRESS 312 S. Eden St.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Joseph		First	Middle	Last	4. DATE OF DEATH Yacola	Month 11	Day 7	Year 1958			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-86		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months —	IF UNDER 24 HRS. Days —	Hours —	Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vendor		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Unknown					
13. FATHER'S NAME —		14. MOTHER'S MAIDEN NAME —									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Record-Springfield State Hospital, Sykesville, Md.		Address —					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0		DUE TO —				INTERVAL BETWEEN ONSET AND DEATH more than 10 years.					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. { (b) DUE TO — (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I CBS assoc. with disturbance of metabolism, growth, nutrition, with senile brain disease. With psychotic reaction. Fecal impaction.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —		(State) —	
21. I certify that I attended the deceased from July 22 , 19 57 , to Nov. 7 , 19 58 , that I last saw the deceased alive on Nov. 6 , 19 58 , and that death occurred at 4:03 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Walter Knopp, M.D.						ADDRESS (Street, city or town, state) —		DATE SIGNED 11-7-58			
PHYSICIAN'S NAME (Type) Walter Knopp, M.D.		22b. DATE THEREOF 11/10/58		22c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer		22d. LOCATION (City, town, or county) Balt. Md.		(State) —			
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. REC'D BY REGISTRAR —		24b. REGISTRAR'S SIGNATURE —							
23. FUNERAL DIRECTOR'S SIGNATURE Frank Delle Dror #322 S. High Street		ADDRESS —		DATE NOV 13 '58							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 may be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12371

CERTIFICATE OF DEATH

12305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll, County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (22)		d. STREET ADDRESS 810 Mildred Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield, State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Zippler Leo		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
		Leonard	Zippler		November 15,			1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1888	9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Adam Zippler		14. MOTHER'S MAIDEN NAME Mary ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes		16. SOCIAL SECURITY NO. WWL 213-07-3933		17. INFORMANT Mrs. Ellen Spahn		Address 810 Mildred Ave. 22		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease						INTERVAL BETWEEN ONSET AND DEATH years.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Generalized arteriosclerosis (c)						years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. due to cerebral arteriosclerosis Bronchopneumonia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Springfield		(County) Md. (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Agustin del Campo</i>						ADDRESS (Street, city or town, state) Springfield State Hospital.		
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland.				DATE SIGNED 11-16-58		
22a. BURIAL, CREMATION, (Specify) Burial		22b. DATE THEREOF Nov. 20, 58		22c. NAME OF CEMETERY OR CREMATORIUM Balto. National		22d. LOCATION (City, town, or county) Frederick Road Md.		
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA 7922 Wise Ave. 22, Md.		ADDRESS		24a. REC'D BY REGISTRAR NOV 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

REF ID: A6510

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